TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. executed within 24 hours after death TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate Page 4 may be retained by the hospital or attending physician.

| | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | |
|---------------|---|--|--------------------------------------|--|--|--|
| | 02974 CERTIFICATE | | 02955 | | | |
| 1. | PLACE OF DEATH a. COUNTY ALL I C O YOU I C O MARYLAND | 2. USUAL RESIDENCE (Where deceased lived, If institution: Re a. STATE Maryland b. COUNTY Wic | sidence before admission) | | | |
| | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | c. CITY OR TOWN (if outside corporete limits, write RURAL: Salisbury | and give nearest town) | | | |
| _ | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | d. STREET ADDRESS | e. IS RESIDENCE ON A FARM? | | | |
| L | ENINSULA GENERAL HOSPITAL | 427 Elizabeth St | YES NO NO | | | |
| 3. | NAME OF DECEASED (Type or print) SEX 6. COLOR OR RACE MADDIED NEVER MADDIED 18 | Last GNEW 4. DATE Month OF DEATH FEBRUAR DEATH FEBRUAR 19. AGE (In years I IF UNDER) | Day Year 1966 | | | |
| F | EMALE WHITE WIDOWED DIVORCED F | Teb. 19/1886 79 yrs. 11 | Deys Hours Min. | | | |
| 10a dur | a. USUALOCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY HOuse None | CO | UNTRY? | | | |
| 13. | . FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | | | | |
| | Harry Round | Emma Richardson | | | | |
| 15 (Ye | is. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. Mr. 18. SOCIAL SECURITY NO. 19. Mr. 19. Mr. 19. Social Security No. 19. Social Security No. 19. Mr. 19. Social Security No. 19. Social Security | s.Elizabeth Marie Seabreau 27 Elizabeth St Salisbury | se(Daughter | | | |
| 1 | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | * | INTERVAL BETWEEN ONSET AND DEATH | | | |
| | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | - | -3 days | | | |
| | Conditions, If any, which | | 2 - 1/2 | | | |
| | gave rise to immediate (cause (a), stating the DUE TO | | | | | |
| | underlying cause last. (c) | | | | | |
| CERTIFICATION | PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELAT | TED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | 19. WAS AUTOPSY PERFORMED? YES NO NO | | | |
| | 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCUP OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | IRRED. (Enter nature of Injury In Pert I or Part (I of Item 18.) | | | | |
| MEDICAL | | CE OF INJURY (Home, farm, 20f. (City or town) (Courry, street, office bldg., etc.) | nty) (State) | | | |
| | 21. I certify that (I) (this hospital) attended the deceased from | | , that (I) (we) last | | | |
| | saw the deceased alive on 2-4 1966, and that | t death occurred at 2 30 M, from the causes and on th | e date stated above. | | | |
| | 11/ 1/3 Smith M.D. | ATTENDING MED. STAFF DIRECTOR PHYS. | 4-66 | | | |
| | NAME (Type)Dr. William B. Smith | Salisbury Maryland | | | | |

BURIAL, CREMATION, BEMOVAL (Specify) Burial 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State) 23a. 23d. Park Salisbury, Maryland
REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE
D 7 1966 Records Judge Feb.6/1966 Memorial Park Wicomico ADDRESS 24. FUNERAL DIRECTOR 25a. SALISBURY, MARYLAND DATEB 1966 COMPANY

VR A15 (4)

Maryland Vicquico

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150=10-7772 May salameth Marie Schieses D ughter

Language, wande Late

Just 1 Reb. 6/1966 Honorice Percental Park Dilebury, Wireland

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OF TABLES AND A LABOR OF THE PARTY OF THE PA

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE 02975 MEDICAL EXAMINER'S CERTIFICATE OF HEALTH DEPT PLACE OF DEATH e. COUNTY USUAL RESIDENCE (Where deceased lived, If institution: Residence before b. COUNTY Wicomico e. STATE Wicomico Maryland MARYLAND Department after death. essany funeral CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH DF STAY IN 1b may Salisbury (Rural 3-Months Willards the 5 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street eddress) 6. IS RESIDENCE DN A FARM? d. STREET ADDRESS any delay is 2, and 3 to ti State hours U.S. Route#50 Naylor Mill Road NO A YES NAME OF DATE Yee First Middle Last Month DECEASED FEBRUARY 21 1966 WALTER THOMAS ALEXANDER DEATH (Type or print) 2 with within AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS DATE OF BIRTH 6. COLOR OR RACE 9. TY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, r. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form d for your files. 7. MARRIED NEVER MARRIED last birthday) Days Months 6 Sept.20/1902 WIDOWED T DIVDRCED N White and s 12. CITIZEN OF WHAT COUNTRY? 1De. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) during most of working life, even if retired) ges 1 Retired Driver-salesman4011 USA Wicomico Co. Maryland pages Lavinia C.Bailey J.Earl Alexander File Cooper(Sister)Ocean City 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 117. INFORMANT (Yes. no. or unkown) | (If yes give war or dates of service) permit. I No Willards Maryland NTERVAL DETWEE 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I, DEATH WAS CAUSED BY: burial-transit cremation, or IMMEDIATE CAUSE (e) cremation, DUE TO Conditions, if any, which (b) geve rise to immediate DUE TO ceuse (e), steting the 50 underlying cause lest. used as to burial, WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO X YES DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 1) of Item 18.) 35 2Da. EXTERNAL CAUSE WAS PRIMARY TO OF CONTRIBUTING TO CAUSE OF DEATH. should ! 3 shou agent, MEDICAL 20c. TIME OF INJURY Month, Dev. Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, ferm, fectory, street, office bidg., etc.) 20f. (City or town) (County) (State) Hour e.m. While of work of work TO FUNERAL DIRECTOR: Page of Health or its designated and in my opinion 21. I certify that I took charge of the remains described above, held an Autopsy Inspection Undetermined manner death resulted from: Natural causes X Accident Suicide Homicide CHIEF MEDICAL EXAMINER 22. DATE SIGNED ACTUAL ASSISTANT MEDICAL EXAMINER M.D. SIGNATUE Rover DEPUTY MEDICAL EXAMINER IK EXAMINER'S 09 please ex director. retained Address (Street, city, town, or county) Feb. Ave Salisbury Md Camden 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) BURIAL, CREMATION, 23b. Burial (Specify) 1966 Co. Delaware Smith-Mills Cem. Sussex REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS SALISBURY MARYLAND VR A15ME (5) HOLLOWAY & COMPANY

MARYLAND STATE DEPARTMENT OF HEALTH

---Bus Cyron wollessi! coimoi Beatliv Salisbury (Aurel) 2- Vonths D.S. Doubelie Myler Mill Bood MBINGER 21 66 WALTER THOMAS ALEXANDER Sept. 20/1902 63 2 5/1/ Setired Driver-selection(Oll Co.) Micomico Co., Mrylens U S A Lablage C.Peller ABBRESTA DESS. L Des Malande Cooper St Des Coram City 4.50

11/31

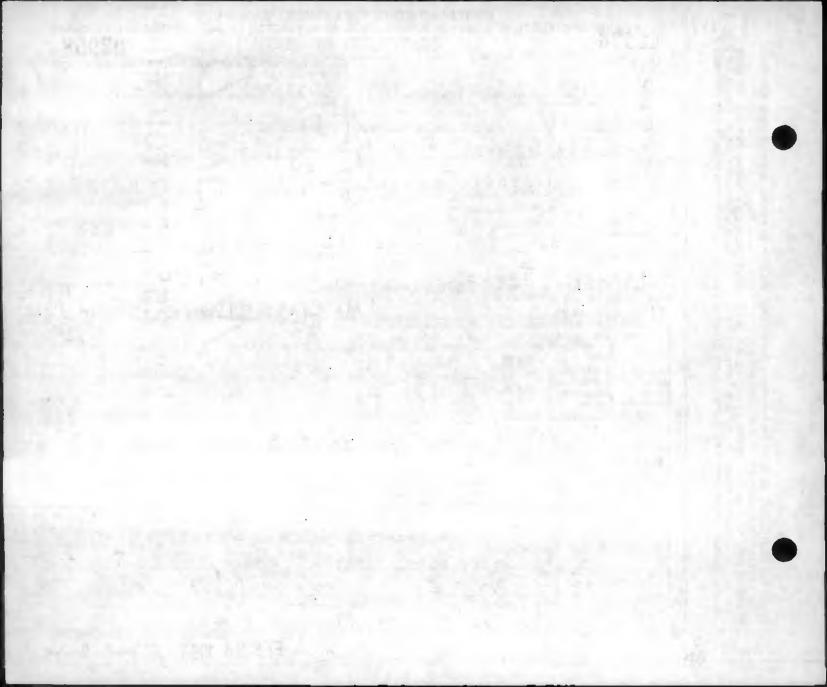
Je. Borl l. Pavet 909 Conden AverSklishury, Md

Sucial Feb. 23/1966 Smith_Hills Cem. Suchex Co., Delicate

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ECOLOGIAN SOLISSIONS, MARYLAND

| | 1 (1 | M |) | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND O2976 CERTIFICATE OF DEATH | | | | | | | | | |
|-------------------|---|------|----------|--|---|---|---|---|---|---|---|------|---|
| after death. | by the funeral Pages 1 and 2 urs after death. | | 1. | PLACE OF DEATH a. COUNTY WICOMICO MARYLAND b. CITY OR TOWN (If outside corporate limits, c, LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | | | | | |
| 24 hou | filled in papers. in 72 ho | 20 | | wilte RURAL and give nearest town) A LISBURY D. NAME OF HOSPITAL OR INSTITUTION (If not in hospitel, give street address) DENINSULA GENERAL HOSPITAL RED 2 ON A FARM YES D NOT | | | | | | | | | |
| executed within | comple ve car event, | | 3. 5. | NAME OF DECEASED (Type or print) SETSEY TAYLOR BAKER BEATH G. COLOR OR RACE 7. MARRIED NEVER MARRIED NEVER MARRIED NOT BIRTH EMALE White WIDOWED DIVORCED JUNG 14. 1916 WITH MONTH Day Year MONTH DAY YEAR IF UNDER 24H HOURS MI | | | | | | | | | |
| certificate be ex | physiciant and please remo | | dur | USUAL OCCUPATION (GIVe kind of work done in the property of working life, even if retired) 10b. KIND OF BUSINESS OR II. BIRTHPLACE (County & State, or foreign country) 11c. CITIZEN OF WHAT COUNTRY? 11c. BIRTHPLACE (County & State, or foreign country) 11c. CITIZEN OF WHAT COUNTRY? 11c. BIRTHPLACE (County & State, or foreign country) 11c. CITIZEN OF WHAT COUNTRY? 11c. BIRTHPLACE (County & State, or foreign country) 11c. CITIZEN OF WHAT COUNTRY? 11c. BIRTHPLACE (County & State, or foreign country) 11c. CITIZEN OF WHAT COUNTRY? 11c. BIRTHPLACE (County & State, or foreign country) 11c. CITIZEN OF WHAT COUNTRY? 11c. BIRTHPLACE (County & State, or foreign country) 11c. CITIZEN OF WHAT COUNTRY? 11c. BIRTHPLACE (County & State, or foreign country) 11c. CITIZEN OF WHAT COUNTRY? 11c. BIRTHPLACE (County & State, or foreign country) 11c. CITIZEN OF WHAT COUNTRY? 11c. BIRTHPLACE (County & State, or foreign country) 11c. CITIZEN OF WHAT COUNTRY? 11c. BIRTHPLACE (County & State, or foreign country) 11c. CITIZEN OF WHAT COUNTRY? 11c. BIRTHPLACE (County & State, or foreign country) 11c. CITIZEN OF WHAT COUNTRY? 11c. BIRTHPLACE (County & State, or foreign country) 11c. CITIZEN OF WHAT COUNTRY? 11c. BIRTHPLACE (County & State, or foreign country) 11c. CITIZEN OF WHAT COUNTRY? 11c. BIRTHPLACE (County & State, or foreign country) | | | | | | | | | |
| death | the attending pharmit. Then ation, or removal | | | WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address R. 7. D & MR CYRUS B. BAKER BERLING INTERVAL BETWEE | | | | | | | | | |
| res that the | 700 | | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which } DUE TO Conditions, if any, which } DUE TO Conditions, if any, which } | | | | | | | | | |
| The law requires | has been as the as the prior to | | FICATION | gave rise to immediate ceuse (a), stating the underlying ceuse last. (c) CUNOMA A TOPE PERFORMED PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPS PERFORMED YES NO | | | | | | | | | |
| | is certific ached for ept. of Ke | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | CERT | 20a. ACCIOENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Pert 1 or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State |
| OR ATTENDING PI | camed by the FOR: After the should be det th the State D | | MEDICAL | Hour e.m. p.m. 19 While at work factory, street, office bldg., etc.) 21. I certify that (I) (this hospital) attended the deceased from 7077, 1966, to 773, 1966, that (I) (we) I saw the deceased alive on 1966, and that death occurred at 978, from the causes and on the date stated about 1966. | | | | | | | | | |
| O HOSPITAL OR AT | # F B = B | 1 | | 228. SIGNATURE M.D. ATTENDING MED. DIRECTOR STAFF 22b. OATE SIGNEO 22c. PHYSICIAN'S NAME (Type) H. F. Brigle 22d. ADDRESS NAME (Type) H. A. Brigle 22d. ADDRESS | | | | | | | | | |
| = | 2 | 0 | 232 | BURIAL STORIAL BERLING 11/2. | | | | | | | | | |
| 41 | R A15 (4) | 1830 | 1 | N. burge belle I DATE - TO 1000 1 - The first | | | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02977 CERTIFICATE OF DEATH

| 1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAN | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico |
|---|--|
| b. CITY OR TOWN (if outside corporate limits, write RUBAL and give nearest town) Salisbury | Salisbury 24-/ |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address 201 Holland Ave | d. STREET ADDRESS 201 Holland Ave. o. is residence on a farm? YES \(\sum \) NO \(\sum \) |
| 3. NAME DF PIRST Middle EDWARD FRANCIS | BOOTH 4. DATE Month Day Year OF DEATH FEBRUARY 13 19 66 |
| 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCED | 3 8. DATE OF BIRTH 3 Jan. 14/1895 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 HRS. Months Days Hours Min. Mi |
| during most of working life, eyen if retired in our shop ewas | - Doily and James and American |
| 13. FATHER'S NAME Frank J. Booth | Annie Hastings |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unkown) (If yes give war or dates of service) 220-32-0562A | Mrs. Carrie M. Booth (Wife) 201 Holland Ave. Salisbury, Maryland |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).3 PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Underlying cause last. | tevsive CV, Disease 3 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT F JACON DO PROTECTION OF THE SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT F 202. ACCIDENT WAS UNDERLYING TO DESCRIBE HOW INJURY OF CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A | PRELATED TO THE FERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO |
| 3 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. | PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) actory, street, office bidg., etc.) |
| 21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1966, and 22a. SIGNATURE | that death occurred at OOPM, from the causes and on the date stated above. |
| 220. PHYSICIAN'S NAME BYOP, G. Herbert Sembly | M.D. ATTENDING X DIRECTOR STAFF PHYS. Feb. 14/1966 22d. ADDRESS E. Church St. Salisbury, Maryland |
| 238. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMEN BURIAL (Specify) Feb. 16/1966 Wicomico 1 | Memorial Park Salisbury, Maryland |
| 24. FUNERAL DIRECTOR ADDRESS HOLLOWAY & COMPANY SALISBURY, MAI | RYLAND DATE B 15 1966 A Charles Judge |

VR AIS (4) (20M 1/65

and completely filled in by the funeral remay, carbon papers. Pages 1 and 2 an

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician a director, page 3 should be detached for use as the burial-transit permit. Then please in should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in

San Prepare agish i colsoniwoudal /c2 voudoi/a8 . ave Amalloh 105 201 Hollowd Ave PRANCIS CL VENTLEY estin Jan.14/1895 0506 Retired Barber (Burber whom comer) Selimbury, Forgres sanifadE siami Midoga T Kens 220-32-0562A Mrs.Corrie M. Booth(Mire) 201 Holland

ANZ

400:8-9qa

7 /1966

Dr.G. Hernert Sembly E.Church St. Smlisbury, Maryland
Eurisi Peb.16/1966 Wicomico Memorial Park Enliabury, Maryland
HOLLOWY & CONDANY SILISBURY, MARYLAND

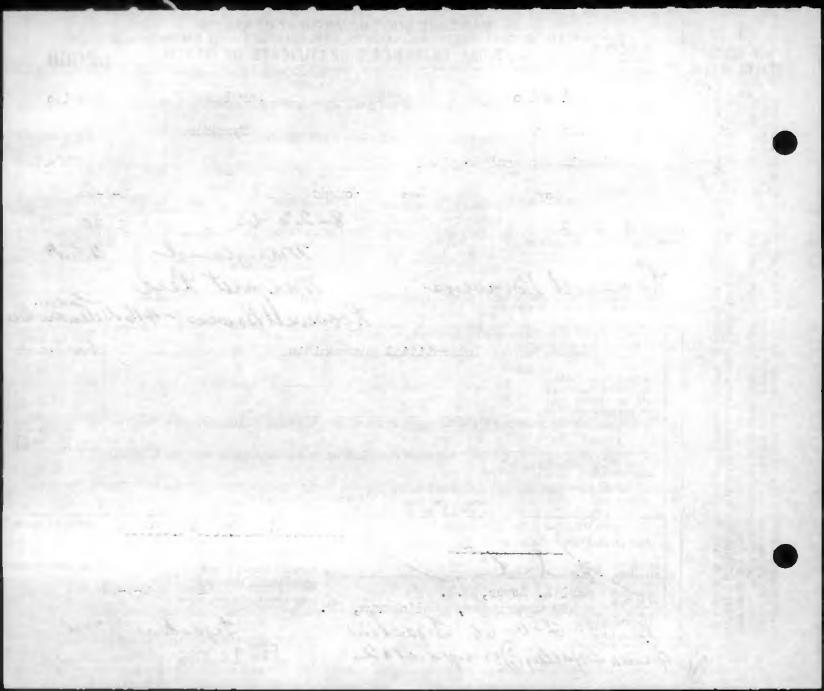
FOR STATE HEALTH DEPT

O DEPUTY MEDION EXAMINER: This certificate should be examined within 24 hours after death. If any delay accessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. permit. File pages 1 and 2 with the State Department removal, and In any event within 72 hours after death. used as a burlal-transit to burial, cremation, or TO FUNERAL DIRECTOR: Page 3 should be of Health or its designated agent, prior TO DEPUTY MEDIC

> VR AISME (5) 5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

| - | UGO 80 WIEDIOAL EXAMINER 3 | CERTIFICAL | E OF DEAT | n (| 1241111 |
|---------------|--|-----------------------------|-------------------------|------------------------------------|-------------------------------|
| 1. | PLACE OF DEATH a. COUNTY | 2. USUAL RESIDENCE | | d, If institution: Re b. COUNTY | sidence before admission |
| 4 | Wicomico MARYLAND | 1 | familand | Tol | H comico |
| | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | c. CITY OR TOWN (I | outside corporate III | mits, write RURAL | and give hearest town) |
| | Salisbury | | Twaskin | 2 | 2-1 |
| | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | d. STREET ADORESS | 7 | | e. IS RESIDENCE ON A FARM? |
| 1 | D | • | | | YES NO |
| 1= | Peninsula Gen eral Hospital | | | 11 | |
| 13. | NAME OF First Middle DECEASED | Last | 4. DATE | Month | Day Year |
| 1 | (Type or print) Roy Lee Bo | wens | DEATH | 2-3 | -66 19 |
| 5, | SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIEO 8 | B. DATE OF BIRTH | 9. AGE (In | years IF UNDER 1 | LYEAR HE UNDER 24 HRS |
| | MIDOWED DIVORCED | 8-23- | 1.5 last bit | | Days Hours Min. |
| 10 | Da. USUAL OCCUPATION (Give kind of work done) 10b. KINO OF BUSINESS OR | 11. BIRTHPLACE (S | state or foreign count | утв. Б | 20 TIZEN OF WHAT |
| du | iring most of working life, even if retired) INDUSTRY | II. BIRTHPLACE (S | state of intellin commi | 0 00 | UNTRY? |
| | | mar | Mane | | 4.5.1. |
| 13 | FATHER'S NAME | 14. MOTHER'S MAIL | DEN-NAME | 2 ' 1 | |
| | Transmit Brance | mana | 21174 | 0.11 | |
| 11 | 5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. | JNFORMANT CO | aru c | Address | |
| (Ŷ | (es, no, or unkown) ((fryes give war or dates of service) | A 1. | n | 11 11 | - Dalla ! |
| | Te | cosevelt | Doweno: | -416N | elaunte un |
| | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | INTERVAL BETWEEN |
| | PART I. DEATH WAS CAUSED BY: Interstitial pneu | monitia | | | DASET AND DEATH |
| | IMMEDIATE CAUSE (a) Interstitial pneu | MIGITALS | | | |
| | DUE TO | | | | |
| | Conditions, if any, which gave rise to immediate (b) | | | | |
| | cause (a), stating the DUE TO | | | | |
| | underlying cause last. (c) | | | | |
| 2 | | TEO TO THE TERMINAL | DISEASE CONDITION G | IVEN IN PART 1(a) | 119. WAS AUTOPSY |
| Ĕ | | | | | PERFORMED? |
| 100 | | | | | YES NO |
| CERTIFICATION | 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCU | RRED. (Enter nature o | f injury in Part I or P | art II of Item 18.) | |
| 193 | PRIMARY OF CONTRIBUTING CAUSE OF DEATH. | | | | |
| | | CE OF INJURY (Home, fa | | town) (Cour | nty) (State) |
| MEDICAL | Hour a.m. While Not While factor | ry, street, office bldg., 6 | etc.) | | |
| ME. | | | | | |
| | 21. I certify that I took charge of the remains described above, hel- | d an Autopsy 💢, | Inspection X, | Inquiry X, | and in my opinion |
| | death resulted from: Natural causes X, Accident , Sui | cide , Homici | de Undete | rmined manner | |
| | 1-8-1- | CHIEF MEDICA | L EXAMINER | | |
| | ACTUAL / | ASSISTANT ME | DICAL EXAMINER | 1 | 22. DATE SIGNED |
| | SIGNATURE | | P-17 | | |
| | EXAMER'S Earl L. Royer . X.D. | | CAL EXAMINER | 2-6-66 |) |
| 1 | NAME (Type) | -10/- | t, city, town, or coun | | |
| 23 | a. BURIAL CREMATION; 23b. DATE THEREOF 23c. HAME OF CEMELERY | OR CREMATORY | 23d. LOCATION | (City, town or cou | nty) (State) |
| | Burge 3-6-66 Jungerin | | Juan | Reser | mel, |
| 2 | 4. FUNERAL DIRECTOR) OPERESS, | 25aRE | C'D BY REMSTRAR | 25b. REGISTRAR'S | S SIGNATURE |
| 12 | Exitty D. Jolley, Jerseyka, Rt & 2 | T.FE | B 1 4 1966 | Miliane | Can Quedat |
| 4 | | DATE | - 1004 | 1 | - Junge |
| | 5-179597 | | | | |



MARYCAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02073
CERTIFICATE OF DEATH

| 11 | | 1/24.313 | Įl. |
|-----------------|--|---|--|
| 1. P | LACE OF DEATH | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residen | ce before admission |
| | Wieemice MARYLANO | a. STATE Maryland b. COUNTY Wicom | ico |
| b | C. LENGTH OF STAY IN 1b write RURAL and give nearest town) | c. CITY OR TOWN (If outside corporate limits, write RURAL and g | |
| | Mardela Mardela | Mardela 2: | |
| d | 1. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | d. STREET ADORESS | e. IS RESIDENCE |
| | Charles Street | Eharles Street | ON A FARM? |
| a N | IAME OF First Middle | Last 4. DATE Month Oa | YES NO X |
| (F) | Type or print) CHARLES EDWARD 1 | DE | .2 19 66 |
| 5. S | 6. COLOR OR RACE 7. MARRIED NEVER MARRIEO | 8. OATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR last birthday) Months Days | |
| | | July 3/1879 86 yrs. Months Days | Hours Min. |
| 10a.U during | JSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR gmost of working life, even if retired) INOUSTRY | 11. BIRT HPLACE (County & State, or foreign country) 12. CITIZEN COUNTR | |
| La | aborer (Package Co.) | Mardela, Maryland U | |
| 13. | FATHER'S NAME | 14. MOTHER'S MAIOEN NAME | |
| Je | ohn Brown | Mary Phippin | |
| 15. W | VAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. no. or unkown) (If yes give war or dates of service) | INFORMACIO | 1 |
| No | 217-09-1354 PT | B. Virginia L. Mezick (Daughter | ') |
| 11 | 8. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | ERVAL BETWEEN |
| | PART I. DEATH WAS CAUSED BY: | | SET AND DEATH |
| | IMMEDIATE CAUSE (a) / Carollac | Jechyphonation 2 | 4 040 |
| _ | renditions if any which \ | I Por | |
| | ave rise to immediate | fr. cerous | - you |
| | ause (a), stating the OUE TO | 1 / 2 | 0 |
| | ART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA | ITED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 | WAS AUTOPSY |
| ATIC | NATIONAL STREET TO AND TO STREET TO STREET TO STREET BOT NOT KEEN | | PERFORMED? |
| 를 _~ | ACCIDENT WAS HARRIVING TO 1 20h DESCRIPT HOW MILLION OCCU | | ES NO |
| F語 10 | 10a. ACCIDENT WAS UNDERLYING TO 20b. DESCRIBE HOW INJURY OCCUPATE ON THE PROPERTY OF THE PROPE | RRED. (Enter nature of Injury In Part I or Part II of Item 18.) | |
| 정 2 | Oc. TIME OF INJURY Month, Oay, Year 20d. INJURY OCCURRED 20e. PLA | CE OF INJURY (Home, farm, 20f. (City or town) (County) | (State) |
| MEDICAL | Willie Multiple | ry, street, office bldg., etc.) | |
| Σ - | p.m. 19 at work at work 21. I certify that (I) (this hospital) attended the deceased from | 10 4- 10 4 | that (IV four) faul |
| | | t death occurred a M. from the causes and on the da | that (I) (we) last |
| 2 | 22a. SIGNATURE | 22b. OATE S | |
| | My / / / showing | ATTENDING MEO. STAFF | 14/// |
| 2 | 22c. PHYSICIAN'S M.D | I. PHYS. DIRECTOR PHYS. 1. | 1-64 |
| | NAME (Type) r. George & Schlesinger | Mardela, Maryland | |
| 23a. | OR CREMATORY 23d. LOCATION (City, town or county) | (State) | |
| | BEMOVAL (Specify) | 0 | |
| 24. | FUNERAL DIRECTOR ADDRESS | 25a, REC'D BY REGISTRAR 25b. REGISTRAR'S SIG | |
| HO | LLOWAY & COMPANY SALISBURY MARY | EED a built soul a co | 1.100 |
| | THOUSE OF THE PROPERTY OF THE | CHAIND DATE - TO GOOD A CONTROL Y | The state of the s |

TO HOSEITAL OR ATTENBING ENVERTIANT The law regulars that the death certificate be executed within 24 llours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIREGIOR: After this certificate has been signed by the attending Mysician director, page 3 should be detached for use as the burial-transit permit. Then please it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in

VR A15 (4) 20M 1/65

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, throw carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

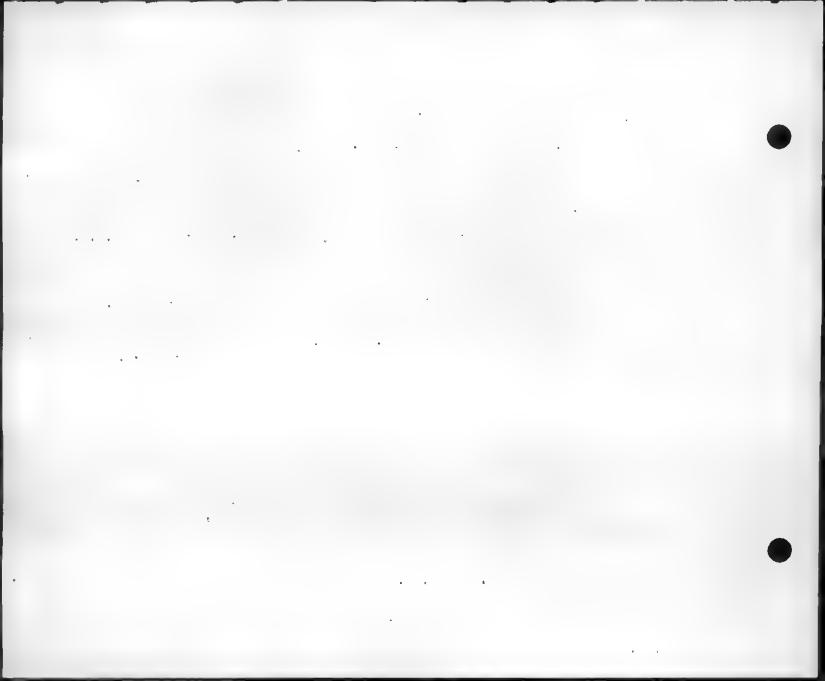
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH

AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND DIVISION OF STATISTICAL RESEARCH CERTIFICATE OF DEATH

| 1. PLACE OF DEATH a. COUNTY | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) | | | | | | | |
|--|--|--|--|--|--|--|--|--|
| Wicomico Maryland | a. STATE B. COUNTY Caroline | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | c. CITY DR TDWN (if outside corporate limits, write RURAL and give nearest town) | | | | | | | |
|) 007 Dana | Dankan | | | | | | | |
| Salisbury d. NAME OF HOSPITAL DR INSTITUTION (if not in hospital, give street address) | Denton d. STREET ADDRESS 1 e. IS RESIDENCE | | | | | | | |
| | ON A FARM? | | | | | | | |
| Deer's Head State Hospital, Salisbury, Md. | Rt. #2, Box 146 YES NO | | | | | | | |
| 3. NAME OF First Middle DECEASED | Lest 4. DATE Month Day Year | | | | | | | |
| (Type or print) PHTL | BURTON DEATH Feb. 21 19 66 | | | | | | | |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | 8. DATE OF BIRTH 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS. last birthday) Months Days Hours Min. | | | | | | | |
| Male Negro WIDOWED DIVORCED | June 13, 1921 4: yrs. Months Days Hours Min. | | | | | | | |
| 10a. HSHAL OCCUPATION (Sive kind of work done) 10b. KIND DE BUSINESS OR | 13 DEDTED ACE (County & State or fourier country) 12 CITIZEN OF WHAT | | | | | | | |
| during most of working life, even if retired) NDUSTRY | dt. Yeser adox, "I'r inia | | | | | | | |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | | | | | | | |
| Preston Burton | Rebecca Wise | | | | | | | |
| | INFORMANT Address | | | | | | | |
| (Yes, no, or unkown) ((If yes pive war or dates of service) | | | | | | | | |
| 1,0 | r. Tlendelia Turton, Denton, Md. T.T | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (Sarcinoma of rt. max | illary antrum with advanced 5 years | | | | | | | |
| PUE TO | | | | | | | | |
| Conditions to any which \ | metastases. | | | | | | | |
| gave rise to immediate | | | | | | | | |
| cause (a), stating the DUE TO | | | | | | | | |
| | ATED TO THE TERMINAL DISEASE CONDITIONGIVEN IN PART 1(a) 119. WAS AUTDPSY | | | | | | | |
| THE THE STATE OF T | PERFORMED? | | | | | | | |
| CO AND DESCRIPTION OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY | YES NO X | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE PART II. OTHER SIGNIFICANT CONTRIBUTING TO THE PART II. OTHER SIGNIFICANT CONTRIBUTION CONTR | JRRED. (Enter nature of Injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME DF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLA | CE OF INJURY (Home, farm, 20f. (City or town) (County) (State) | | | | | | | |
| TET NOT WITH THE NOT WITH THE | vry, street, office bldg., etc.) | | | | | | | |
| | 7/29 , 19 65 , to 2/21 , 19 66, that (I) (we) last | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from | | | | | | | | |
| saw the deceased alive pn 2/21 1966, and that | t death occurred at 1 OM, from the causes and on the date stated above. | | | | | | | |
| V. Juliuan M. | ATTENDING - MED. STAFF PER COLOR /// | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) Tuerman M T) | Deer's Head State Hospital, Salisbury, Md. | | | | | | | |
| NAME (Type) Y. Juerman, M. D. Peer's Head State Hospital, Sal | | | | | | | | |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERS | | | | | | | | |
| mill 12-75-7 Tederalsy 11 | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| J. J. Traptom and Son, Federal Stury, tar | J. I. Truptom and Son, redecelature larvland wiEB 24 1956 Charley Judge | | | | | | | |

5 (4) 1/65 VR AI5 20M 1,



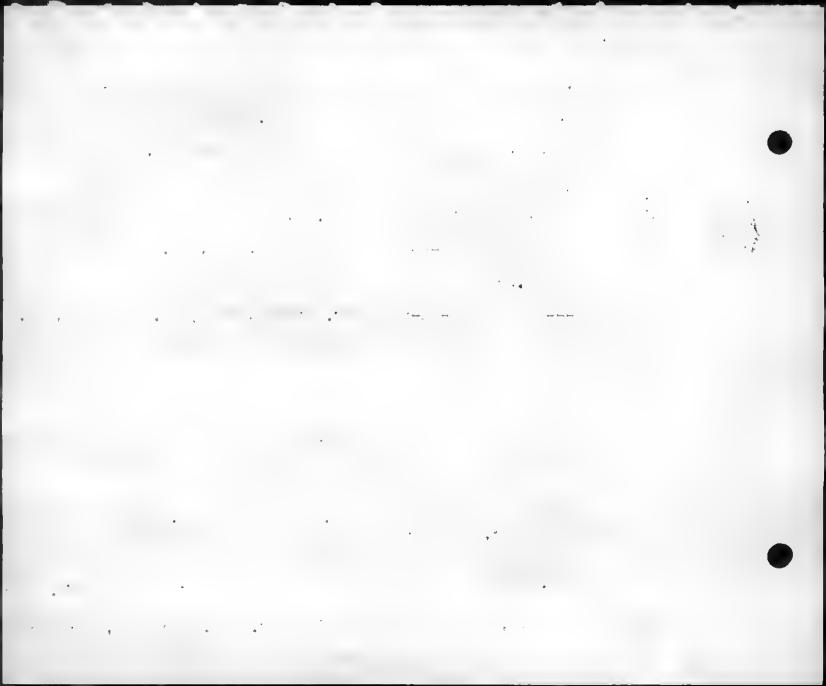
in and completely filled in by the functal sections and a section papers. Pages I and a section, within 72 hours after earth, Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then places allower carbon papers. Pages 1 and a should be filled with the State Dept. of Health prior to burial, cremation, or removal, and income, within 72 hours after depth.

| | MARYLAND STATE DEPARTMENT OF HEALTH | |
|-------------|---|------------------|
| DIVISION OF | STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIF | MORE 1, MARYLAND |
| 32881 | CERTIFICATE OF DEATH | 12:63 |

| 1. PLACE OF DEATH a. COUNTY | | E (Where deceased lived, If institut) | on: Residence before admission) | |
|--|--|--|------------------------------------|--|
| Wicomico MARYLAND | e. STATE Maryland b. COUNTY Talbot | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) | | | |
| Salisbury 3 months | St. | Michaels | * .* | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | d. STREET ADDRESS | | e. IS RESIDENCE | |
| Deer's Head State Hospital | 1.07 | Carpenter St. | ON A FARM? YES NO | |
| 3. NAME OF First Middle DEGEASED | Last | 4. DATE Month | Day Year | |
| (Time to all A) | arr | OF DEATH 2 | 12 19 66 | |
| | . DATE OF BIRTH | 9. AGE (in years) If UN | IDER 1 YEAR IF UNDER 24 HRS. | |
| Female Colored WIDOWED TO DIVORCED M | ar. 3, 188 | | | |
| 10a. USUAL OCCUPATION (Give kind of workdone during most of working life, even if retired) INDUSTRY | | ounty & State, or foreign country) 1 | 2. CITIZEN OF WHAT COUNTRY? | |
| Housewife | Talbot Co | ounty, Md. | USA | |
| 13. FATHER'S NAME | 14. MOTHER'S MAID | EN NAME | | |
| John Schuyler | Kate So | | | |
| | INFORMANT | Address | | |
| Ne 219-01-5719 Mr | s. Sarah | Jeshus, St. Mi | charle Ma | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | I INTERVAL BETWEEN | |
| PART I. DEATH WAS CAUSED BY: Arteriosclerotic (| Cardiovascul | ar Disease | YOUSET AND DEATH | |
| 4 2 21 DUE TO | | | | |
| Conditions, if any, which (b) | | | | |
| gave rise to immediate cause (a), stating the DUE TO | | | | |
| underlying cause last. (c) | | | | |
| PARTILOTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE PARTILOTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE PARTILOTHER SIGNIFICANT CONTRIBUTING TO CAUSE OF DEATH OR CONTRIBUTIONS TO CAUSE OF DEATH OR CONT | TED TO THE TERMINAL O | ISEASE CONDITION GIVEN IN PART | 1(a) 19. WAS AUTOPSY PERFORMED? | |
| 0ld Cerebral Thrombosis with right Hem | iparesis | | YES NO | |
| 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCUP OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | RRED. (Enter nature of | Injury in Part I or Part II of Iter | n 18.) | |
| | | | | |
| 3 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLAC | CE OF INJURY (Home, fary, street, office bidg., e | rm, 20f. (City or town) | (County) (State) | |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLAC Hour a.m. While Not While at work at work | 1) all eer's mice mag" e | | | |
| 21. I certify that (I) (this hospital) attended the deceased from De | ec. 1/1 19 | 65 to Feb. 12, 1 | 1966_, that (1) (we) last | |
| saw the deceased alive on Feb. 12 19.66, and that | | A.M. from the causes and | on the date stated above. | |
| 22a. SIGNATURE | ATTENDING - | MED. STAFF X 221 | D. DATE SIGNED | |
| V. Juliudic M.D. | . PHYS. | DIRECTOR PHYS. | | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Juerman | Deer's | Head State Hospi | tal, Salisbury, | |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY | OR CREMATORY | 23d. LOCATION (City, town of | or county) (State) | |
| Burial Feb 15.1966 Thomas Memo | orial Cem. | St. Michael | a Manulant | |
| 24. EUNERAL DIRECTOR ADDRESS | 25a. REC | St. Michael | RAR'S SIGNATURE and | |
| I Wan Stotra Havering At mixed | ago DAFEE B | 15 1966 Pla | rle: | |
| | vud) | # | | |

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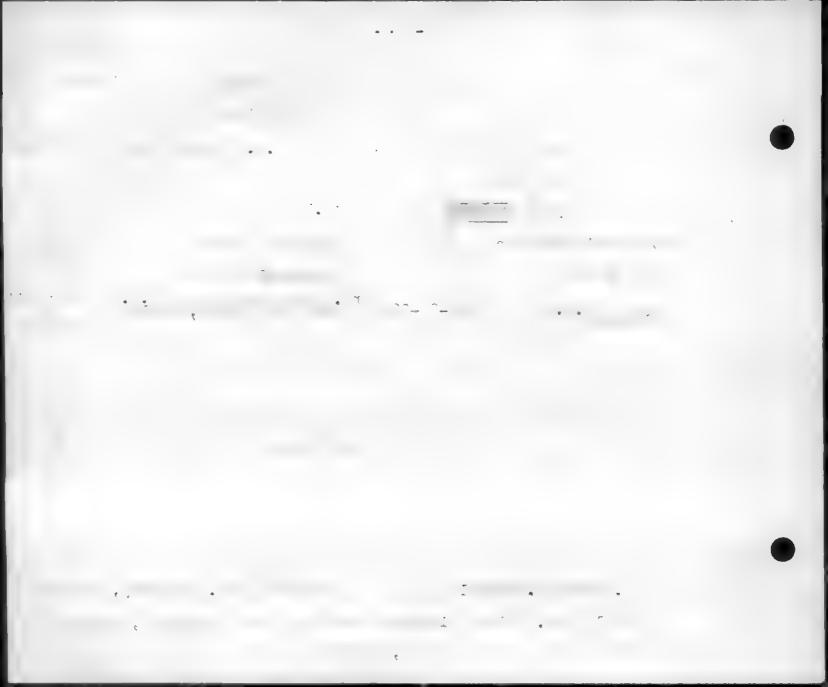
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 12082

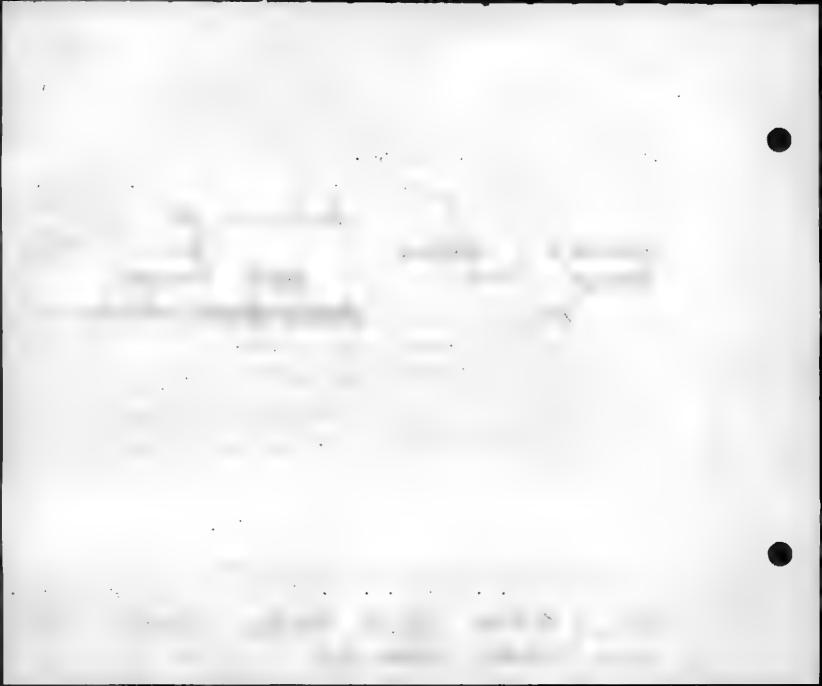
| - 1 | | |
|-----|---|---|
| ÆI) | PLACE OF DEATH a. COUNTY . / | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) |
| 4/ | Nicomico MARYLAND | e. STATE Maryland b. COUNTY Wicomico |
| 1- | b. CITY OR TOWN (If outside corporate limits, c, LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporete limits, write RURAL and give nearest town) |
| | write RURAL and give nearest town) | Salisbury |
| - | A) NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | d. STREET ADDRESS 1 e. IS RESIDENCE |
| Ш | | ON A FARM? |
| _ | Peninsula General Nospital | R.D.#4 Ocean City Rd YES NOTE |
| 1 | 3. NAME OF First Middle DECEASED | Last 4. DATE Month Day Year |
| | (Type or print) LOUIS B | hames DEATH FRETURRY 27 19 66 |
| 1 | 77 WHITTED A HEVER MARKING | 8. DATE OF BIRTH 9. AGE (In years IF UNDER/1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Min. |
| | Male WHITE MINIONIAN DIVORCED | Feb. 16/1896 70 yrs. 0 6 hours |
| | 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT |
| | during most of working life, even if retired) INDUSTRY Restaurant Operator | Greece (Patras) US A |
| | 13. FATHER'S NAME | 1 14. MOTHER'S MAIDEN NAME |
| | Bill Chames | |
| - | | Panagoula Fakos |
| | (Yes, no, or unknown) (If yes give war or dates of service) | s.Agnes Chames(Wife)R.D.#4 Ocean Cit |
| | YESW.W.#I 220-32-0394 | Road Salisbury Maryland |
| | 18. Leader of DEATH [Enter only one cause per line for (a), (b), and (c)e] | INTERVAL BETWEEN ONSET AND DEATH |
| | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Enery Thrember is |
| -1 | DUE TO A | |
| | Conditions, If any, which) to Parties Silver | Fir Heat During |
| -1 | gave rise to immediate | |
| | underlying agree leet | |
| | | ATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19, WAS AUTOPSY |
| | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA | PERFORMED? |
| 4 | | YES X NO |
| | S OR CONTRIBUTING □ CAUSE OF DEATH | JRRED. (Enter nature of injury in Pert I or Part II of Item 18.) |
| | (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| | 3 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLA | CE OF INJURY (Home, farm, 20f. (City or town) (County) (State) |
| | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLA facto while pm. 19 at work at work | 15, an eet, on to sing, etc./ |
| - [| 21. I certify that (I) (this hospital) attended the deceased from | 1954, 19 to 19 that (1) (we) last |
| | saw the deceased alive on 2/2/66 19 and that | t death occurred at A AM, from the causes and on the date stated above. |
| | 22a. SIGNATURE | 22b. DATE SIGNED |
| ą | (2) C In Dard | ATTENDING MED. STAFF |
| | 22c. PHYSICIAN'S | D. PHYS. DTRECTOR PHYS. 122d. ADDRESS |
| | NAME (Type) | Maryland Ave. Salisbury, Maryland |
| - | | |
| | 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY REMOVAL (Specify) | |
| 1 | | morial Park Salisbury, Maryland |
| | 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |
| M | HOLLOWAY & COMPANY SALISBURY, MARY | LAND prie B 2: 15 10 Milarley Judge |

VR A15 (4) 15M 4-64



20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trans: t permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and hear event, mithin 72 hours after death.

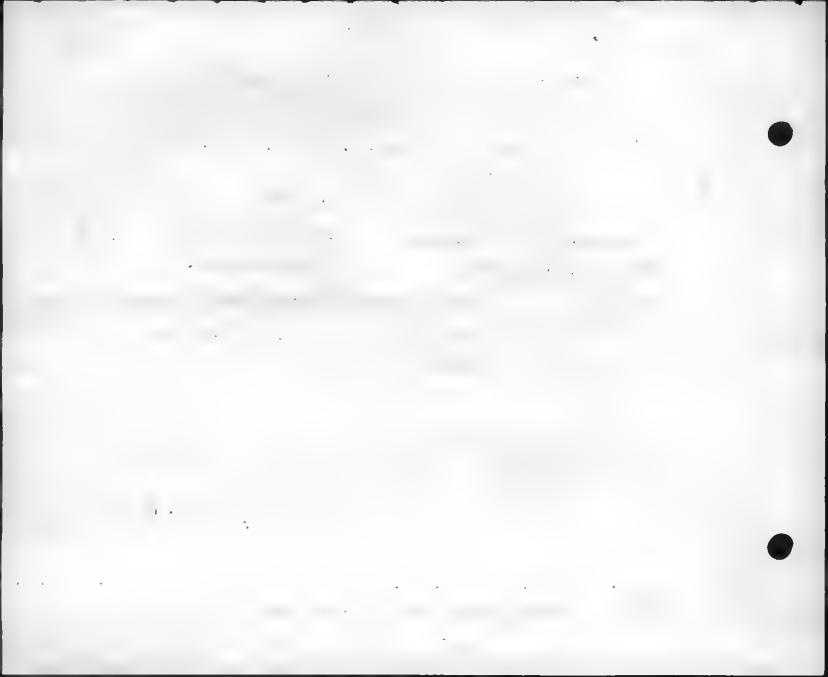
> VR A15 (4) 15M 4-64

| | | | STATE DEPAI | | | | |
|----------|----------------|-------------|----------------|---------------|-----------|-------------|----------|
| DIVISION | OF STATISTICAL | RESEARCH AN | ID RECORDS, 30 | DI W. PRESTON | STREET, B | ALTIMORE 1, | MARYLAND |
| 00084 | OF STATISTICAL | CEF | RTIFICATE | OF DEATH | CALL S | 4 | 2966 |

| Item #6 Film CERTIFICATE OF DEATH |
|---|
| 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) |
| a. COUNTY DIEDZINEO MARYIAND B. STATE LOCALINE B. COUNTY |
| b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| write RURAL and give nearest town) |
| Salis Bury accornacy Ca" |
| e. IN AME OF HOSPITAL DR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? |
| |
| 1 6,000 |
| DECEASED OF TO |
| (Type or print) Lybyah M- Clark DEATH Freb. 11 1960 |
| 5. SEX 6. COLOR OR/RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 HRS. last birthday) Months Days Hours Min. |
| MIHLE Nazro WIDOWED DIVORCED WITH S DAYS HOURS MIN. |
| 10a. USUAL OCCUPATION (GIVE kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT |
| during most of working life, even if retired) LADUSTRY O |
| fractile school vice |
| 13. FATHER'S NAME |
| matthew Clark Elizabeth Emans |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17, INFORMANT Address |
| (Yes, no, or unknown) (If yes give war or dates of service) 2 30-42.5397 Do Ally Clark - Uconnac, Va |
| |
| ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: Levelored Homierary age |
| 33/X DUE TO 11 " |
| Conditions, If any, which (b) Hy Der lension and |
| gave rise to immediate |
| Eve ma letter care but |
| CC (C) |
| PERFORMED? |
| AES NO |
| 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Part of Item 18.) |
| (IF EITHER, NOTIFY MEDICAL EXAMINER) |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) |
| Hour a.m. While Not While factory, street, office blyig., etc.) |
| |
| 21. I certify that (I) (this hospital) attended the deceased from 2/0/, 1926, to 2/1/, 1964, that (I) (we) last |
| saw the deceased alive on 1960, and that death occurred at 252M, from the caused and on the date stated above. |
| 22a. SIGNATURE 22b. DATE SIGNED |
| M.D. PHYS. DIRECTOR PHYS. |
| 22c. PHYSICIAN'S |
| NÂME (Type) |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY DR CREMATORY 23d. LOCATION (City, town or county) (State) |
| REMOVAL (Specify) Fan (6.16) Indian To 100 100 100 100 100 100 100 100 100 10 |
| General Tel-15/960 Whater wom. Fletwelly, ou |
| 24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |
| 5 Aga Whalow - scramac, Uar Jake B 16 1956 Harles Judge |
| |



| 1 | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAN | ID OIL |
|--|--|------------------|
| 0/ | 02985 CERTIFICATE OF DEATH 9096 | 7 |
| after death. the funeral ges 1 and 2 after death. | 1. PLACE DF DEATH 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before | re admission) |
| 43 (1) | Wicomico Maryland Talbot | |
| rs afte by the Pages urs afte | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | arest town) |
| 2 2 2 | Salisbury 6 days Easton d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS | RESIDENCE |
| Page age | Deer's Head State Hospital. Salisbury Md. 306 Hanson Street | NA FARM? |
| 7 | 3 NAME OF First Middle last 14 DATE Month Day | Year |
| e executed within ian and completely se remoye carbo 1 in any event, with | OFFICE OF PRINT ROLLING CLARK FORMAN 7 | 19 66 |
| eve eve | | NDER 24 HRS. |
| and and rem | MILLE WIDOWED DIVORCED 3014 31, 10 1 66 yrs. 6 7 | /HAT |
| be ician ase nd ii | during most of working life, even if retired) INDUSTRY | |
| ate | MECHANIC SALESMAN CHICOLINE COUNTY U.SA. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME | |
| certificate be e nding physician a Then please r removal, and in | JAMES MARINE CLARK LONA TOWERS | |
| sath certifications attending a sermit. There in, or remove | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) [(If yes give war or dates of service), | N |
| deatl | NO 11745 THE WAR OF DATES OF SERVICE) 213-01-8408 MRS, ROLAND CLARK FASTON-MD. 21 | |
| OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. IRECTOR: After this certificate has been signed by the attending physician ge 3 should be detached for use as the burial-transit permit. Then please ed with the State Dept. of Health prior to burial, cremation, or removal, and is | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I, DEATH WAS CAUSED BY: The destruction of the control of th | ND DEATH |
| cian. cian. ed b ed b tran. | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema with bilateral Bronchopneumonia Day | /S |
| es the physical signal controls of the physical control controls of the physical control control controls of the physical control control control controls of the physical control | 500.10 | lonths_ |
| een to b | gave rise to immediate (| 7 |
| tenditendias bas bas the | underlying cause last. (c) Right Carotid Artery Stenosis 2 f | Ionths S AUTOPSY |
| he Is or at the h use alth | PE | RFORMED? |
| Ne. T | Right Hemiparesis YES () 20a, ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part or Part of Item 18.) | <u>L.</u> |
| cer cer ched ot. o | OR CONTRIBUTING COURT CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| PHYS the this this detac | ZDC. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm, left) 4 Hour a.m. While Not While Not While at work at work at work 2Dd. PLACE OF INJURY (Home, farm, left) 2Of. (City or town) (County) (County) | (State) |
| NG by the free be considered by the considered b | Hour a.m. p.m. 19 While at work at work | |
| END! | 21. I certify that (I) (this hospital) attended the deceased from February 1, 1966, to Feb. 7, 1966, that | |
| ATT reta coro sh with | saw the deceased alive on February 7 19 66, and that death occurred at TOPM, from the causes and on the date st | D aten appae |
| DIR DIR | M.D. ATTENDING MED. STAFF 2/8/66 | |
| may may RAL ', pa | 22c PHYSICIAN'S 22d. ADDRESS Deer's Head State Hospital. Sali | - Ma |
| ge 4 UNE UNE ecto | Guoteri ez-dari rad | (State) |
| TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death of Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attendirector, page 3 should be detached for use as the burial-transit permitshould be filed with the State Dept. of Health prior to burial, cremation, or | 238. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) FEBRUARY 10,1964 SPRING HILL CEMETERY EASTON - MARY LAN | |
| 0 | 24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATU | RE |
| VR AIS (4) | Billio Casta Taston Marefrand Dire B 11 1966 Jelianles Jud | ye |



FOR STATE HEALTH DEPT.

please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TH BEFRETY BILLIA

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages I and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in a gent within 72 hours after death.

MADVIAND STATE DEDARTMENT OF HEALTH

| | INIMIN | THILD STALE DE | CPARIMENI UP | DEMEIL | 1 | |
|--------------------|--------------|----------------|-------------------|---------|--------------|----------|
| Division of STATIS | STICAL RESEA | RCH AND RECORD | S, 301 W. PRESTON | STREET, | BALTIMORE 1, | MARYLAND |
| | | | CERTIFICATE | , | | 112371 |

| $\Lambda -$ | The second second | | | | | | |
|-----------------------|---|--------------------------|----------------------------|------------------------------------|-------------------------------|---|--|
| 1 | . PLACE OF DEATH | | | | | nstitution: Residence before admission) | |
| 1 | Wicomic | 0 | MARYLAND | a. STATE b. COUNTY Marylandicomico | | | |
| Г | b. CITY OR TOWN (If outside c write RURAL end give near | orporate Hmits, | c. LENGTH OF STAY IN 15 | | | vrite RURAL and give nearest town) | |
| | Salisha | | Par | sonsbur : | , | | |
| Г | d. NAME OF HOSPITAL OR INST | ITUTION (if not in hos | pital, give street address | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? | |
| | reninsu | la General | Hospital | Kou | ive 2 | YES NO NO | |
| 3 | . NAME DF | First | Middle | Last | 4. DATE Mon | th Day Year | |
| | DECEASED (Type or print) | RIMY | LEE | DAVIS | OF DEATH | 2-1-66 19 | |
| 5 | . SEX 6. COLOR OR | RACE 7. MARRIED | NEVER MARRIED X | 8. DATE OF BIRTH | 9. AGE (In years | IFUNDER 1 YEAR IFUNDER 24 HRS. | |
| | Male Whit | _ | DIVORCED | Dec. 2, 1 | 950 last birthday | Months Days Hours Min. | |
| 1 | Da. USUAL OCCUPATION (Give kind o | of work done , 10b. Kill | D OF BUSINESS OR | | State or foreign country) | 12. CITIZEN OF WHAT | |
| 10 | uring most of working life, even it Student | | mentry Sch | odl Milf | ord. Del. | USA | |
| 1 | 3. FATHER'S NAME | 1 776 | mentry sen | 14. MOTHER'S MAII | | IUDA | |
| L | Ernest Dav | 1 9 | | Marrie | Tunch | | |
| 1 | 15. WAS DECEASED EVER INU.S. AR | MED FORCES? 16. S | OCIAL SECURITY NO. 17 | , INFORMANT | Addr | ess | |
| 10 | Yes, no, or unkown) (If yes give war o | | Mana | Same at The sec | å a Dannanal | | |
| == | NO | | | rinest bav | is, Parsonsl | I INTERVAL BETWEEN | |
| П | PART 1. DEATH WAS CAUS | ONSET AND DEATH | | | | | |
| П | IMMEDIATE CAUSE (e) DIADETIC ACIDOSIS. | | | | | | |
| | Conditions if any whiteh | | | | | | |
| | Conditions, if eny, which gave rise to immediate (b) Diabetes Mellitus. | | | | | X | |
| | couse (a), stating the | DUE TO | | | | 0 | |
| ١, | underlying causa last. PART II. OTHER SIGNIFICANT CO | (c) | INC TO DO THE OUT HOT DE | ATTO TO THE TERMINAL | DISCASS COMPLETION CIVEN I | N PART 1(a) 19. WAS AUTOPSY | |
| | PART II. O'MEN SIGNIFICANE CO | MDILIONS CONTRIBUT | ING TO DEATH BUT NOT KE | LATED TO THE FERMINAL | BISENSE COMPLLION GIATIAL | PERFORMED? | |
| . 5 | | | | | f later to Back the Back th | YES X NO | |
| MEDICAL CERTIFICATION | 20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. | 205. DI | SCRIBE HOW INJURY OC | CURRED, (Enter nature o | f injury in Part I or Part II | or item 18.) | |
| 140 | 20c. TIME OF INJURY Month | , Day, Year 20d. IN. | JURY OCCURRED 200. P | ACE OF INJURY (Home, f. | arm, 20f. (City or town) | (County) (State) | |
| I I | Hour a.m. | 19 While et work | Not While of work | tol J, sti cet, office plog., t | 510.7 | | |
| 2 | 21. I certify that I took | | | eld an Autopsy | Inspection X, Inc | uiry X, and In my opinion | |
| П | | latural causes X. | | uicide . Homici | | | |
| П | | 0 (/) | noordent | CHIEF MEDICA | | | |
| | ACTUAL SIGNATURE | 16/8- | 2 | M.D. ASSISTANT ME | | 22. DATE SIGNED | |
| | Earl L | . Royer, E. | DA | | CAL EXAMINER X | 2-1:-66 | |
| , | T F Y RAPTA FR'C | 2 | Salisbury, | d. Address (Stree | et, city, town, or county) | 2-0-00 | |
| 2 | 3a. BURIAL, GREMATION. 23b. | DATE THEREOF | 23c. NAME OF CEMETE | RY OR CREMATORY | 23d. LOCATION (City, | town or county) (State) | |
| | Burial 2 | /4/66 | Parsonsbu | rg Cemeter | y Parson: | sburg. Ld. | |
| - | 24. FUNERAL DIRECTOR | 1 | ADDRESS | 25a. RE | C'O BY REGISTRAR 25b. | REGISTRAR'S SIGNATURE | |
| | Dennis Buner | al Home, Sn | ow Hill. Id. | DAFEE | 3 8° 1956 <i>,1</i> ° | . Sudre | |
| - | | | | 1 5754 50 | . A A A | 1 1 | |



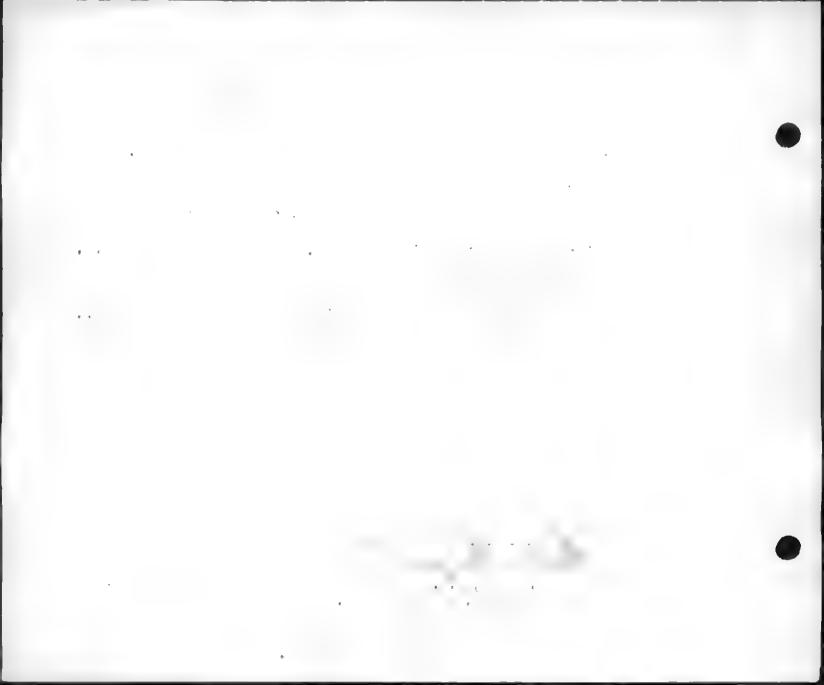
VR A15 (4) 15M 4-64

| | MARYLAND STATE DEPARTMENT OF HEALTH | |
|----------------|--|---|
| DIVISION OF | STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, | BALTIMORE 1, MARYLANI |
| 92287 | CERTIFICATE OF DEATH | 02971 |
| PLACE OF DEATH | 1 2 USUAL RESIDENCE (Where decease | ad lived of institution: Residence before |

| | 1. | PLACE OF DEATH | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) |
|-----|---------------|--|---|
| Y | | a. COUNTY. WARYLAND | a. STATE b. COUNTY |
| | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| | | SALISBURY | Rural Snew Hill |
| - 1 | | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | d. STREET ADDRESS 6. IS RESIDENCE ON A FARM? |
| ٨ | | Peninsula General Hespital | YES NO E |
| | 3. | NAME OF First Middle DECEASED | Last 4. DATE Month Day Year OF |
| | 5. | APV 1 A ADVANCE AND ADVANCE AN | 8. DATE OF BIRTH 9. AGE (In years FUNDER 1 YEAR IFUNDER 24 HRS. |
| | // | 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCED DIVORCED | Scot. 3 1908 5 7 yrs. Months Days Hours Min. |
| 1 | 10a | USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR Ing most of working life, even if retired) | 11. BIRTHALACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? |
| | | Laborer Manufacturaine Many | Warcester Co. Maryland H.S.A. |
| | 13. | FATHER'S NAME | 14. MOTRER'S MAIDEN NAME |
| | | Marien Dickerson | Mary E. Burke |
| | | . WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. | INFORMANT |
| | | No 213 16 7606 1E | |
| | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: | INTERVAL BETWEEN ONSET AND DEATH |
| | | IMMEDIATE CAUSE (a) | ratory tailure 1267 |
| | | DUE TO OA | et la Callerina lucia |
| | | gave rise to immediate (b) | structive compagement years |
| | | cause (a), stating the DUE TO | • 1 |
| | × N | underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELE | ATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 119. WAS AUTOPSY |
| | ATIO | TAKT IN OTHER STIGHT GOAD TO TO SOME SO THAT TO DEATH DOT NOT RED | PERFORMED? |
| 1 | 틸 | 20a, ACCIDENT WAS UNDERLYING TO 20b, DESCRIBE HOW INJURY OCCU | JRRED. (Enter nature of Injury In Part 1 or Part II of Item 18.) |
| | CERTIFICATION | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | , |
| | MEDICAL | - Annin | CE OF INJURY (Home, farm, 20f. (City or town) (County) (State) bry, street, office bldg., etc.) |
| | MED | Hour a.m. While Not While p.m. 19 at work at work | ng salaad amaa add coo. |
| | | 21. I certify that (!) (this hospital) attended the deceased from | Jan 10, 1966 to Fb 17, 1966, that (1) (we) last |
| | Н | | t death occurred at 42 M, from the causes and on the date stated above. |
| | | 22a, SIGNATURE DAM WI | ATTENDING. MED. STAFF |
| 1 | | 22c, PHYSICIAN'S M.C | |
| ţ | | NAME (Type) DAVID RAFAT | Snow Hell Md |
| | 23a | BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERS | Y OR CREMATORY 23d. LOGATION (City, town or county) (State) |
| > | 1 | Surial 2-19-66 MT. Olive C | emetery Snow Hill Mel. |
| 13 | 24 | FUNERAL DIRECTOR ADDRESS | 26a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |
| 1 | _ | formen of Hannia Snow Hill | My DATE EB 21 1966 Jacober Judge |

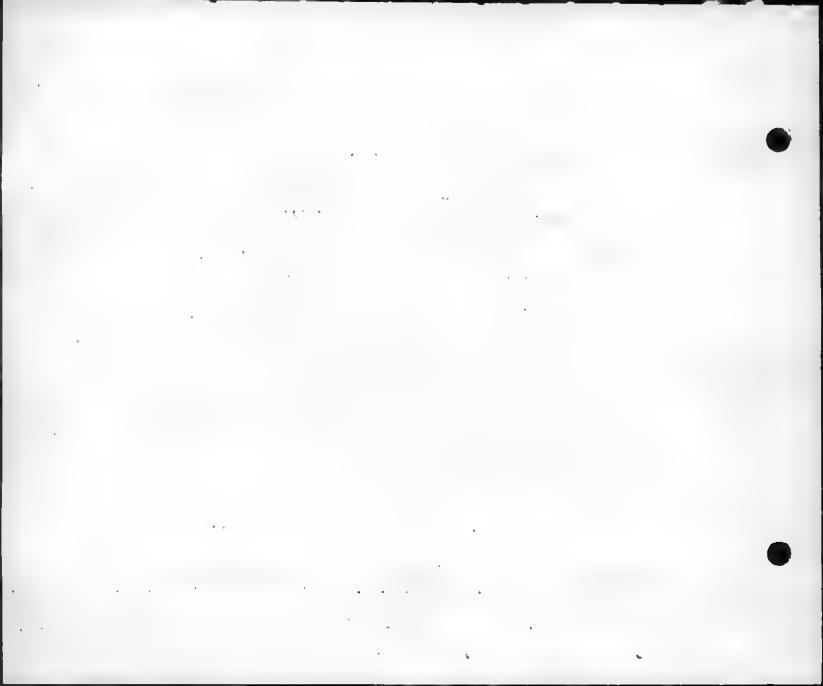


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o STATE 6 COUNTY Page Wicomico Maryland Worcester. ō death. MARYLAND Department b CITY DR TDWN (if outside corporate mits, CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) puo PM3. after Snow Hill d NAME OF HDSPITAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENCE ON A FARM? d STREET ADDRESS hours Peninsula General Hospital 113 Covington St. ate YES NO [24 hours after death 3 NAME OF Middle First 4 DATE 3 51 Lost DECEASED the OF 2-27-66 Elenora Drummond (Type or print) DEATH alang 1 S SEX IF UNDER 1 YEAR 6 CDLOR OR RACE B DATE OF BIRTH AGE (In years JE UNDER 24 HRS 7 MARRIED NEVER MARRIED lost birthdoy) Months Hours 2-27-12 AA WIDOWED DIVORCED Office in Item 1 100 LSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR BIRTHPLACE (State or foreign country) 12 C TIZEN OF WHAT during most of working life, even if retired)
Rouse wife INDUSTRY Md. Domestice Exam ner's pages in any pencli 13 FATHER'S NAME 14 MDTHER'S MAIDEN NAME be executed within Lottie Short Curtis Bishop File IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service remayal. Shirlet Johnson Snow Hill. Md. 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) INTERVAL BETWEEN burial-transit PART I DEATH WAS CAUSED BY ONKET AND DEATH Acute pulmonary edema ā MMEDIATE CAUSE (o) ward This certificate shauld crematian, DUE TO Conditions, if ony, which gove rise to immediate couse (a) DUE TO stoting the underlying couse lost. burial, PERFORMED?
YES NO PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) CERT F CAT 9 20o. EXTERNAL CAUSE WAS 20b DESCR BE HOW INJURY OCCURRED (Enter noture of nury in Port Lor Port Lof Item 18) prior should PRIMARY I or CONTRIBUTING I **EXAMINER:** CAUSE OF DEATH MEDICAL its designated agent, 20c. TIME OF INJURY Month, Doy, Year 20d INJRY OCCURRED 20e PLACE OF NJURY (Home, form, (City or fown) (County) (Stote) Hour a.m. While Not While foctory, street, office bldg., etc.) may be retained far yaur FUNERAL DIRECTOR: Page ot work ot work 21. I certify that I took charge of the remains described above, held an Autopsy 4 Inquiry K and in my apinian the funeral director. death resulted fram. Natural causes A Accident . _Suicide Homic'de Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIG NATURE TO FUNERAL Health or Earl L. Royer. DEPUTY MEDICAL EXAMINER EXAMINER'S NAME (Type) Address (Street, city town, or county) 1,09 Camden Ave. dalishum. 23c NAME OF CEMETERY OR CREMATORY 230 8 RIAL CREMATION. 23d LOCATION (City or Town) Girdletree, Md (Conty) (Stote) REMODEL TRANS Cool Spring Cem. 24 FUNERAL DIRECTOR - ARRESS 2Sq RECD BY REGISTRAR 2Sb REGISTRAR'S S GNATURE VR A15ME (5 Church. New 6M 1766





| | 1 | | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAR CERTIFICATE OF DEATH | YLAND | ž | |
|-------------|---|---------------|--|-------------------------------|----------------|--|
| death. | and 2 death. | 1. | PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Reside a. COUNTY a. STATE b. COUNTY | nce before ad | lm Issien | |
| after | the fees 1 | | Wicomico Maryland Maryland Queen | | | |
| <u>a</u> | युष्ट र | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury 101 Days Chester | give neares | it town | |
| hour | | | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS | e. IS RES | IDENC | |
| 24 | 一 图 二 | D | Deer's Head State Hospital, Salisbury, Md. | YES 🗍 | NO | |
| witlin | completely we carbon to event, with | 3. | DECEASED | ay Yea | ır | |
| | 声 | 5. | (Type of print) Ogle Tilghman Eaton SEX 6. COLOR OR RACE 7. MARRIED ANEVER MARRIED A DATE OF BIRTHON 19. AGE (In years FUNDER 1YE) | 19 | 66 24HR | |
| exemuted | and corremove | 1 | MUDDING TO PROPERTY IN THE PRO | | Min. | |
| _ | n and remo in any | 10: | OB. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZE | N OF WHAT | | |
| - | sicia lease and | aui | Waterman (hester, Maruland US) | COUNTRY | | |
| icalle | 4 - B | 13 | 3. FATHER'S NAME Ogle Tilghman Eaton 14. MOTHER'S MAIDEN NAME Amelia Edenfield | | | |
| certificale | ding ph Then remova | | | | | |
| d≡ath c | e ii: te | (Y | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITYNO. 17. INFORMANT Roy Eaton—Chester, Maryland | | | |
| | atio | | The service of privile and part of the test told told told | TERVAL BET | TWEEN DEATH | |
| that The | signed by urial-transi | | PART I. DEATH WAS CAUSED BY: Cerebral vascular accident | 9 days | 5 | |
| s th | n signe burial- | | Conditions, If any, which (b) Arteriosclerosis, General | 0 | | |
| Tuire | been s the bu | | gave rise to immediate | | | |
| v re | as the | | cause (a), stating the (DUE IU underlying cause last. (c) | | | |
| The lay | | CATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | 9. WAS AU PERFOR YES -X | | |
| TYTICEN: 1 | cert cert red t. of | CERTIFICATION | 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| IG PIIVE | After this code be detached State Dept. | EDICAL | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work at work at work at work | (\$ | State) | |
| | Affica Part Sile Sile Sile Sile Sile Sile Sile Sile | - | 21. I certify that (I) (this hospital) attended the deceased from 10/26 19 55 to 2/4 19 66 | that (I) (v | ve) las | |
| Linksined | S shore | | 21. I certify that (I) (this hospital) attended the deceased from 10/20 19 to 2/4 19 00, saw the deceased alive on 2/4 1966, and that death occurred at 15M, from the causes and on the deceased alive on 2/4 1966. | ate stated | above | |
| E ad | | | ATTENDING MED. STAFF C | | | |
| . 9 | 2 -4 2 - / | ш | 22c. PHYSICIAN'S 22d. ADDRESS | | | |
| ₽ < | FUNERAL director, pa | | NAME (Type) V. Juerman, M. D. Deer's Head State Hospital, Sali | | | |
| FO IIOS | TO FUNE directo should | 23 | 3a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) | 1 1 | tate) | |
| Best | - | 20 | DURICAL 1-60. / STEVENSVILLE STEVENSVILLE, 1-1 OT. 24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR S SI | CNATURE | | |
| VR | A15 (4) | | Edgar L. Jane Church Hill, Maryland DATE 1 1 1998 Mareles | Judge | No. | |
| 49.65 E | 1 355 1 813 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and the superstanting 72 hours after the MARYLAND'STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| _ JAJJ1 | GERTIFICA | IE UF DEATH | 33.177 | | |
|--|--|--|-----------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived, If institution: | Residence before admission) | | |
| Wicomico | MARYLAND | a. STATE Maryland b. COUNTY W | icomico | | |
| b. CITY OR TOWN (if outside corp write RURAL and give nearest | | | | | |
| Mardela | town) | Salisbury | | | |
| | UTION (if not in hospital, give street addres | s) d. STREET ADDRESS | e. IS RESIDENCE | | |
| | de Nursing Home | 215 Marshall Stre | on a farm? | | |
| 3. NAME DF DECEASED | First Middle | Last 4. DATE Month | Day Year | | |
| | ORA MAE | TUNTO DEATH PED. | 19 1966 | | |
| 5. SEX 6. COLOR OR RAI | CE 7. MARRIED NEVER MARRIED | 8. DATE OF BIRTH 9. AGE (In years if UND) last birthday) Months | ER 1 YEAR IF UNDER 24 HRS. | | |
| Female White | WIDOWED X DIVORCED | Dep 6 14/1000 85 yrs. 4 | 20 | | |
| 1Da. USUAL OCCUPATION (Give kind of w during most of working life, even if re | ork done 10b. KIND OF BUSINESS OR tired) INDUSTRY | | CITIZEN DF WHAT | | |
| House work at 1 | | R.D.#Berlin, Maryland | COUNTRY? | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Norris Welleway | | (Umk) | | | |
| 15. WAS DECEASED EVER IN U.S. ARMEE (Yes, no, or unknown) (If yes give war or dat | tes of service) | rs. Helen E. Windsor (Daught arshall St. Salisbury, Mar | er)215 yland | | |
| 18. CAUSE DF DEATH [Enter only | y one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN | | |
| PART I, DEATH WAS CAUSED IMMEDIATE CAL | BY: (etilizat /x | emorte = va | ONSET AND DEATH | | |
| 1 V | OUE TO C | 1 2 3 | 1-27 | | |
| Conditions, If any, which | (b) Keneral ar | terio solerasis | (4) | | |
| gave rise to immediate (| | | | | |
| underlying cause last. | (c) Incurat | C) | 12 40 | | |
| PARTII. DTHER SIGNIFICANT COND 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF E CITY THE CONTRIBUTION CONTRIBUTIO | THONS CONTRIBUTING TO DEATH BUT NOT RE | LATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(4 | 19. WAS ALTDPSY PERFORMED? | | |
| 20a. ACCIDENT WAS UNDERLYING | 20b. DESCRIBE HOW INJURY OC | CURRED. (Enter nature of injury in Part I or Part II of Item 1 | | | |
| 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF CONTRIBUTING CAUSE OF CONTRIBUTION MEDICAL EXA | AMINER) N/A | | | | |
| 3 20c. TIME OF INJURY Month, Da | ay, Year 20d. INJURY OCCURRED 120e. P | | ounty) (State) | | |
| 20c. TIME OF INJURY Month, Da Hour a.m. p.m. | 19 While Not While at work at work | ctory, street, office bldg., etc.) | | | |
| | nospital) attended the deceased from_ | april 10 60 to 2/10 10 | 46_, that (I) (we) last | | |
| saw the deceased alive on: | 1966 and the | nat death occurred at M, from the causes and on | | | |
| 22a. SIGNATURE | , and the | | DATE SIGNED | | |
| 975, | Whlman 1 | A.D. PHYS. MED. STAFF DIRECTOR PHYS. Feb | .12 /1966 | | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | <u> </u> | | |
| NAME (Br.) H.S.K | uhlman | Sharptown, Maryland | | | |
| 23a. BUR AL, CREMATION, 23b. DATE REMOVAL (Specify) BUR1al Feb. | TE THEREDE 23c. NAME OF CEMETE | | | | |
| | | Cemetery Salisbury, Ma | ryland | | |
| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR 25b. REGISTRA | R'S SIGNATURE | | |
| HOLLOWAY & COMPA | ANY SALTSBURY MAR | YTAND LEFR 17 1988 Plens | Par Judge | | |

VR AI5 (4) 2DM 1/65

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then prese, move carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and then yevent, within 72 hours after death.

24 hours after death.

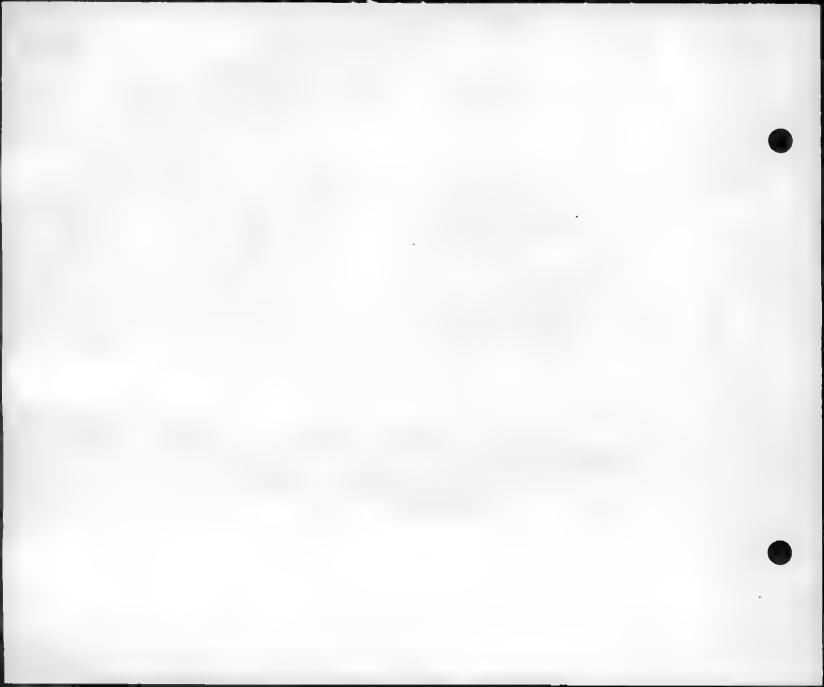
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Page 4 may be retained by the hospital or attending physician.

VR A15 (4) 15M 4-64 MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| 1 | A. CDUNTY | 2. USUAL RESIDENCE (Where deceased lived, if institution: Re- | sidence before admission) | | | | | | |
|--|---|--|---------------------------------------|--|--|--|--|---|---------------------------------|
| I. | | a. STATE //19/10/2 b. COUNTY Acce | macky | | | | | | |
| X | b. CITY OR TOWN (If outside corporate limits, c. LENGTH DF STAY IN 1b | c. CITY DR TDWN (If outside corporate limits, write RURAL a | | | | | | | |
| Ł | write RURAL and give nearest town) | | / | | | | | | |
| 1. | SALISBYRY | RFD New Church : | | | | | | | |
| L | d. NAME OF HDSPITAL OR INSTITUTION (If not in hospital, give street address) | d. STREET AOORESS | e. IS RESIDENCE DN A FARM? | | | | | | |
| 1 | TENINSULA (GENERAL HISDITAL | | YES ND | | | | | | |
| = | 3. NAME OF First Middle | Last 4. DATE Month | Day Year | | | | | | |
| ı | OECEASED (Type or print) BFULAH FTHYL FL | ETCHER DEATH F.E.B. 14 | 1966 | | | | | | |
| - | 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | | YEAR IF UNDER 24 HRS. | | | | | | |
| ı | F Col. WIDDWED DIVORCED | Sep 17, 1960 (5 yrs. Months) | Days Hours Min. | | | | | | |
| ŀ | 1Da. USUAL DCCUPATION (Give kind of workdone, 10b. KIND DF BUSINESS DR | 11. BIRTHPLACE (County & State, or foreign country) 12. CIT | IZEN OF WHAT | | | | | | |
| I | during most of working life, even if retired) Abover | Jesamarak Ulirsinia 1% | JNTRY? | | | | | | |
| 1 | 13. FATHER'S NAME | 14. MDTHER'S MAIDEN NAME | | | | | | | |
| ı | Al The Flotobar | Licia Fields | | | | | | | |
| - | 15. WAS OECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. | | | | | | | | |
| 1 | (Yes, no, or unkown) (If yes give war or dates of service) | | 9 4. KAI | | | | | | |
| 1 | NO 229-09-9064 ct | largis Fletcher Pocomike | | | | | | | |
| ı | 18. CAUSE DF CEATH [Enter only one cause per line for (a), (b), and (c).] | _ | INTERVAL BETWEEN ONSET AND DEATH I | | | | | | |
| Т | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CABCINGMATOSES | | | | | | | | |
| ı | IMMEDIATE CAUSE (a) CADCING MATOSES APP 12 mon. | | | | | | | | |
| П | Conditions, if any, which) (b) ADENOCHBCIREMA COLON | | | | | | | | |
| 1 | gave rise to immediate (| | | | | | | | |
| 1 | Cause (a), Stating the | | | | | | | | |
| П | | ATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | 119. WAS AUTDPSY | | | | | | |
| 1 | E TARTHE SIGNIFICANT CONTENTS CONTINUE TO DEATH DOT NOT REC | WIED IN THE LEGISLINE DISCUST ON WALLING COLUMN 1811 - 1812 - 1813 | PERFORMED? | | | | | | |
| 1 | 2 | | YES ND | | | | | | |
| | PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT REL 202. ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCC DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | URRED. (Enter nature of Injury in Part I or Part II of Item 18.) | | | | | | | |
| 4 | 3 20c. TIME DF INJURY Month, Oay, Year 20d. INJURY OCCURRED 20e. PL | ACE DF INJURY (Home, farm, 20f. (City or town) (Cour | ity) (State) | | | | | | |
| 1 | S Mulle - Not waile - 1 | ory, street, office bldg., etc.) | | | | | | | |
| 1 | p.m. 19 at work at work | | | | | | | | |
| 1 | 21. I certify that (I) (this-hospital) attended the deceased from | | _, that (I) (we) last | | | | | | |
| | saw the deceased alive on 2//4 1966, and that | it death occurred at 45 AM, from the causes and on the | | | | | | | |
| 22a. SIGNATURE ATTENOING MEO. STAFF 22b. DATE SIGNED M.O. PHYS. DIRECTOR PHYS. 2 / 14 / 1966 | | | | | | | | | |
| | | | | | | | | 1 | 22c. PHYSICIAN'S NAME (Type) |
| 1 | NAME (Type) JOHN M. BLOXOM | Mederal Center John | Lein 101X | | | | | | |
| | 23a. BURIAL, CREMATION, 23b. DATE THEREDF 23c. NAME OF CEMETER | , | nty) (State) | | | | | | |
| | BREMOVAL (Specify) 2-20-66 Mt. Zion N | nethodist Withams | 16. | | | | | | |
| | 24. FUNERAL DIRECTOR ADDRESS | (25a. REC'D BY REGISTRAR 25b. REGISTRAR'S | SIGNATIRE | | | | | | |
| ı | 27. Turidaya autrahah | 250; RED O D1 REGIONARE LEGIS REGIONALE | Organione | | | | | | |

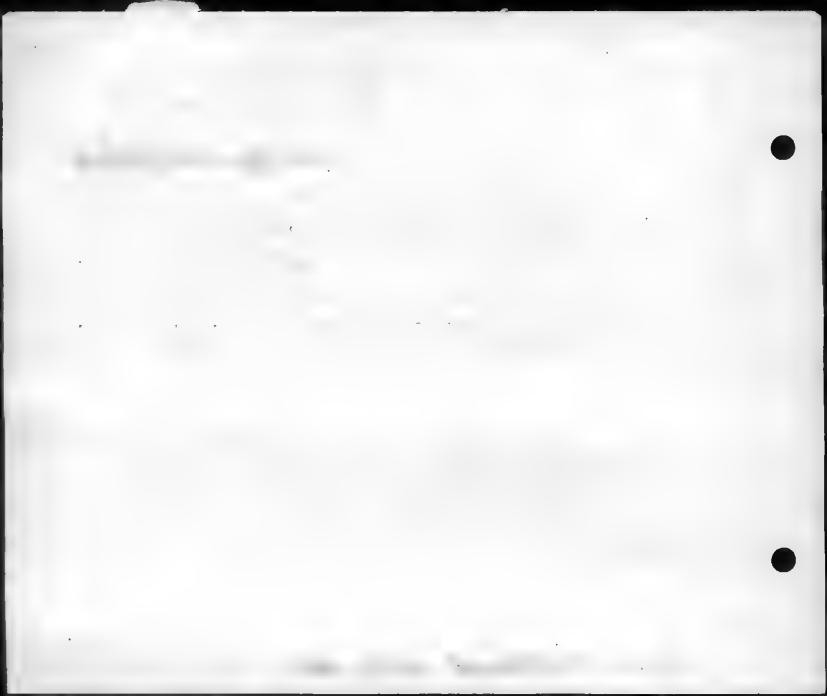


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attendard hysician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Where please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 4-64

| | MADYLAND CTATE DE | TARREST OF HEALTH | |
|---------------|--|---|---------------------------------------|
| | MARYLAND STATE DE DIVISION OF STATISTICAL RESEARCH AND RECORDS | EPARTMENT OF HEALTH IS. 301 W. PRESTON STREET. BALTIMORE 1. MA | ΔΡΥΙ ΔΝΩ |
| | | E OF DEATH | 02070 |
| 1. | PLACE OF DEATH | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Re- | esidence before admission) |
| | 8. COUNTY MARYLAND | B. STATE b. COUNTY | comico |
| | D. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL s | and give nearest town) |
| | write RURAL and give nearest town) | Fruitland | . / |
| | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | d. STREET ADDRESS | ON A FARM? |
| | IEAINSULA (SENERAL HOSPITAL | post office Box truit | ON SES NO K |
| 3. | NAME OF First Middle DECEASED | Last 4. DATE Month | Day Year |
| 5. | (Type or print) LEANCK MAKIE CA) SEX 6. COLOR OR RAGE 7. MARRIED NEVER MARRIED | 8. DATE OF BIRTH 19. AGE (In years) IFUNDER 1 | 19 ((- 1 YEAR) IF UNDER 24 HRS. |
| F | 7. MARKIED N NEVER MARKIED | | Oays Hours Min. |
| 10a | LUSUAL OCCUPATION (Give kind of workdone 10b. KIND OF BUSINESS OR Indignation of the state of th | 11. BIRTHPLACE (County & State, or foreign country) 12. CIT | TIZEN OF WHAT |
| | | Maryland U.S. | Δ |
| 13. | FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | - 31 - |
| 15 | Fredrick vaters i. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 1 17. | Annie wright | |
| (Ye | es, no, or unkown) (If yes give war or dates of service) | INFORMANT Address | |
| - | No 215-36-1356 Et | miley Wright R.F.D.2 Eden | Md |
| | PART I, DEATH WAS CAUSED BY: | ectoral andocardition | ONSET AND DEATH |
| | , IMMEDIATE CAUSE (a) COURT OUT TO | Car que Control Control | 2//4-4-42 |
| | Conditions, if any, which) (b) | | |
| | gave rise to immediate cause (a), stating the DUE TO | | |
| ج | underlying cause last.) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA | ATTE TO THE TECHNIAL CLOCK OF SCOUNDITION CIVEN IN PART 1(2) | 119. WAS AUTOPSY |
| ICATIO | PART II. UTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTTOT NEW | ATED TO THE TERMINAL DISEASE CONDITION GIVEN IN TANTALO, | PERFORMED? |
| CERTIFICATION | 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCUOR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | CURRED. (Enter nature of injury in Part 1 or Part II of Item 18.) | |
| MEDICAL | | ACE OF INJURY (Home, farm, tory, street, office bldg., etc.) (City or town) (Country, street, office bldg., etc.) | nty) (State) |
| | 21. I certify that (I) (this hospital) attended the deceased from | 2/** 4 , 19 66 , to 2/19 , 1966 | 6, that (I) (we) last |
| | | at death occurred at SAM, from the causes and on th | he date stated above. |
| | 22a. SIGNATURE | ATTENDING MED. STAFF | ATE SIGNED |
| | 22 c. PHYSICIAN'S | 1 22d ADDRESS | |
| | NAME (Type) David J. Gilmore, M.D. | Medical Center, Salisbu | ury, Md. |
| 23a | BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETER' | RY OR CREMATORY 23d. LOCATION (City, town or cour | inty) (State) |

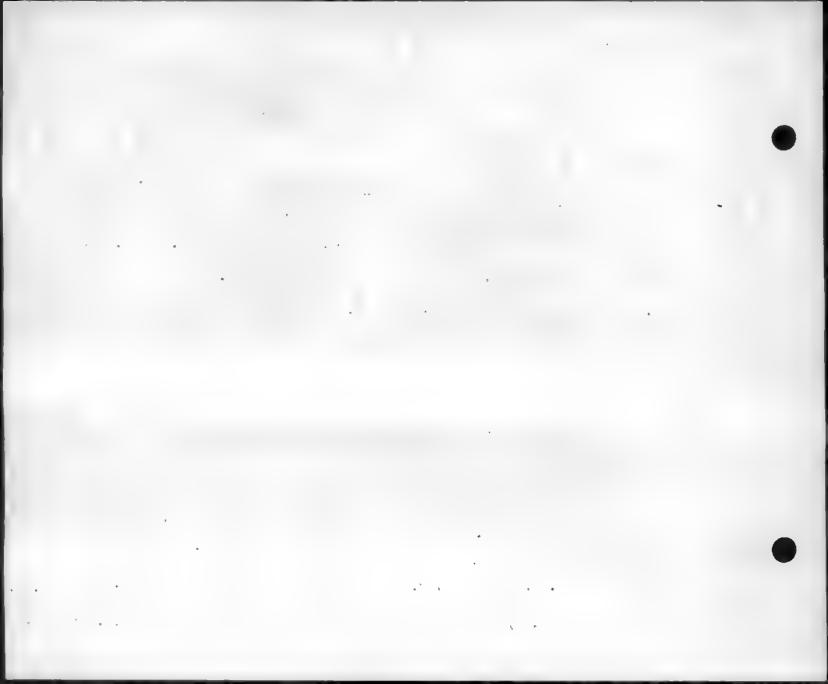
23a. 25b. REGISTRAR'S SIGNATURE Eden REGISTRAR 8 1858 HUPTAL DIRECTOR Eden 25a REC'D BY 24.



DIVISION OF STATISTIC 32594 TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please-remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours/after death. TO HOSPITAL OR ATTENDING PHYDICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

| MARYLAND STATE DEPARTMENT OF HEALTH | |
|---|-----------------|
| CAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIM | ORE 1, MARYLAND |
| CERTIFICATE OF DEATH | 02080 |

| 1 | 1. | PLACE DE DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) | | | | | | |
|-----|---------------|---------------------------------|--|----------------|--|---|--------------|--------------------------------|-------------|------------|----------|---------|
| | | a. COUNTY | Wicomico | | | a. STATE Maryland b. COUNTY Queen Anne's | | | | | | |
| - [| | h CITY OF TOWN | | to Limite | MARYLAND I. C. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If | y I carro | morate limite un | | | | |
| - | | Write RURAL | (if outside corporation and give nearest tow | n) | | | | Iholoto innito, mi | IO NORME O | alo give i | 1601031 | tomij |
| | | Salis | | | 77 days | Sudlersv. | ille | | | 4 | | |
| | | d. NAME OF HOS | PITAL OR INSTITUTIO | N (If not in h | ospital, give street address) | d. STREET ADDRESS | | | | 0, 1 | S RESIL | DENCE |
| 1 | | Deer | Head Stat | e Hospi | ital | | | | | | N A FA | |
| | 3. | NAME OF DECEASED | FI | rst | Middle | Last | 4. DATE | Month | | Day | Year | |
| | | (Type or print) | | trude | | Goodhand | DEAT | н Гев | | 14 | 19 6 | 56 |
| | 5. | SEX | 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED X | B. DATE OF BIRTH | 9 | . AGE (in years last birthday) | | | | |
| | | Female | White | MIDOMED | DIVORCED | April 1,1878 | | 37 yrs. | | | lours | Min. |
| | 1Da | Ing most of work | ION (Give kind of work | done, 10b. K | IND OF BUSINESS OR NDUSTRY | 11. BIRTHPLACE (Co | umty & State | e, or foreign country | | IZEN OF | WHAT | |
| | | ousework | ng mo, even n recite | | ome | Queen Anne | 's Co: | Md. | U.3. | | | |
| | 13. | FATHER'S NAM | | | | 14. MOTHER'S MAID | | | | | | |
| | S | amuel Str | rgis Goodh | and. | | Eugenia Suc | dler. | | | | | |
| | 15. | . WAS DECEASED B | VER IN U.S. ARMED FO | RCES? 16. | SOCIAL SECURITY NO. 17. | INFORMANT | | Addres | is | | | |
| | | No. | (If yes give war or dates o | | 17-36-1731 Wm. | Sudler Goodhand, Sudlersville, Md. 21668 | | | | | | 668 |
| | | | FATU (Enter only on | | Ine for (a), (b), and (c).] | Dudzez ooo | | 044401 | | INTERV | | |
| | | | ATH WAS CAUSED BY | | | A 1 | A. 7a a. A. | | | ONSET | AND DE | EATH |
| | | 1 6 | IMMEDIATE CAUSE | (a) CB1 | ccinoma of righ | t breast wi | | | ana | 22 | ALS | 3 |
| | | 170. | X DUE | TO | | | mas | stectomy | | | | |
| | | Conditions, If a | | (b) | | | | | | | | |
| | | gave rise to cause (a), st | | TO | | | | | | | | |
| | | underlying caus | | (c) | | | | | | | | |
| | 5 | PART II. OTHERS | IGNIFICANT CONDITION | | JTING TO DEATH BUT NOT RELA | TED TO THE TERMINAL D | ISEASE CO | NDITION GIVEN IN | PART 1(a) | 19. W | | |
| | CAT | Hyperte | ensive arte | rioscl | erotic cardiova | scular dise | ase | | | YES | ERFORM | 10 X |
| | 曹 | | | | DESCRIBE HOW INJURY OCCU | | | Part or Part o | f (tem 18.) | 1 . 2 0 | | PAP |
| | CERTIFICATION | OR CONTRIBUTION (IF EITHER, NOT | WAS UNDERLYING THE CAUSE OF DEA | TH NER) | | | ,, | | , | | | |
| | CAL | | NJURY Month, Day, | Year 2Dd. I | NJURY OCCURRED 200, PLA | CE OF INJURY (Home, fa | rm, 20f. | (City or town) | (Coun | ty) | (St | ate) |
| | MEDICAL | Hour a.n | | While at worl | r- not willie | ry, street, office bldg., et | 16.7 | | | | | |
| | 2 | | | | ed the deceased from | 11/29 19 | 65 to | Feb. 1 | 10.66 | that | IIV Isua | tacl (c |
| | | | | Feb. | | , | | | | | | |
| | | 22a. SIGNATUR | eased alive on | - 60. | LAT 1900 and that | death occurred at | : 30 P | rom the causes | 22b. DA | | | above. |
| | | 220. SIGNATOR | 1/ (| 110/16 | . 1 | ATTENDING - A | WED. | CTACC | | | | |
| 1 | | 22c. PHYSICIA | PIC V | Much | M.D | | DIRECTOR | PHYS. | 2/ | 14/6 | 0 | |
| 1 | | NAME (Ty | pe) L. V. | Maldve | , M. D. | Deer's e | ad Sta | te Hospi | tal;Sa | lisb | ury, | Md. |
| | 23a | . BURIAL, CREM | ATION, 23b. DATE | THEREOF | 23c. NAME OF CEMETERY | OR CREMATORY | 23d. L | OCATION (City, to | wh or cour | ity) | (Sta | te) |
| | B | REMOVAL (Spe | Feb. 17 | ,1966 | Sudlersville | Cemetery | Sud: | lersville | , Q.A. | Co; | Mo | d. |
| 1 | 24. | | | - | ADDRESS | / 25a. REC | 'D BY REG | | EGISTRAR'S | | JRE | |
| 2 | , | Paler. | 1 1/ | 137 | 11 / / | DAFEB | 17 4 | 1000 901 | inglar | . 0 | las | |
| | Lin | 14.600 | 1 - allaba | - /// + | 18 1 1 2 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 | DAN E- U | 3, 4 | MUZIN K | 1 5 | A Property | | |



| | MARYLAND STATE DEPARTMENT OF HEALTH | |
|-------------------------|---|------------|
| DIVISION OF STATISTICAL | RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1 | , MARYLAND |
| 1000* | RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1 CERTIFICATE OF DEATH | 112.98 |

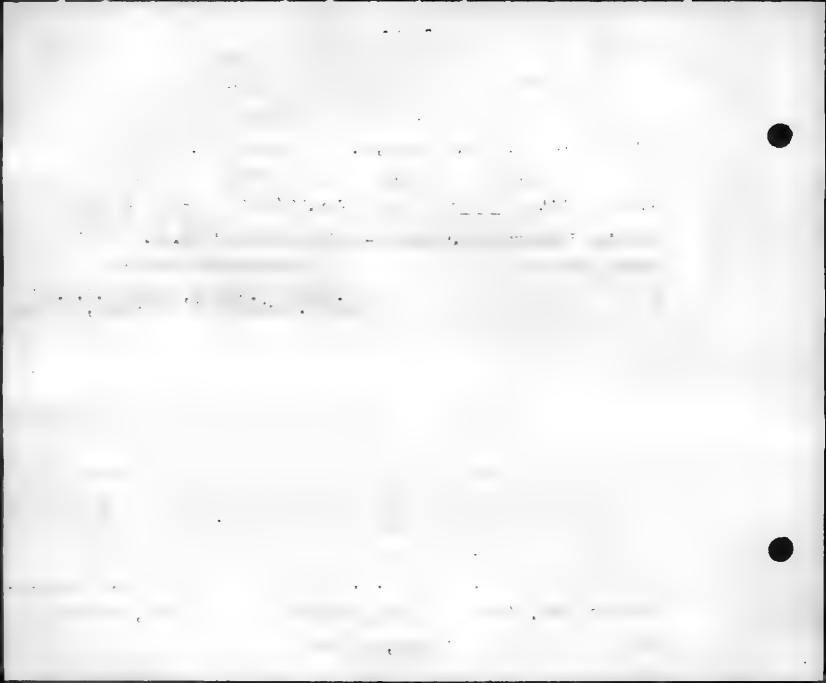
| 1 95'CUS | E OL DEVIU |
|--|--|
| 1. PLACE OF DEATH | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) |
| a. COUNTY | a. STATE b. COUNTY |
| Wicomico MARYLAND | MARYLAND V'ICONICO |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| SALIS BURY | QUANTICO |
| d. NAME OF HDSPITAL OR INSTITUTION (If not in hospital, give street address) | d. STREET ADDRESS e. IS RESIDENCE ON A FARM? |
| PENINSULA GENERAL HOSPITA | YES NO K |
| 3. NAME OF DECEASED FIrst Middle | Last 4. DATE Month Day Year |
| (Type or print) & The Disharbon | JORDY DEATH FEBRUARY 21 19 6/2 |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. |
| | APRIT, 28 1894 69 yrs. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND DF BUSINESS OR | APRIL 28, 1894 69 yrs. |
| during most of working life, even if retired) INDUSTRY | COUNTRY? |
| RETIRED MERCHANDICE | MARYLAND U.S.A. |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
| ELMER T. DISHAROON | LILLIE SMOOT |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. | INFORMANT Address |
| (Yes, no, or unkown) (If yes give war or dates of service) | HERMAN GORDY QUANTICO, MD. |
| 1 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), | INTERVAL BETWEEN |
| PART I. DEATH WAS CAUSED BY: | ONSET AND DEATH |
| IMMEDIATE CAUSE (a) | Webs. |
| DUE TO A | 2 de el como de la laconomia de la como de l |
| Conditions, If any, which to the conditions of t | the work /10 |
| gave rise to immediate | |
| underlyde course leet | |
| | ATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(8) 19. WAS AUTOPSY |
| PARTIL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT REL 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCC BY OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | PERFORMED? YES NO |
| 208. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCC | URRED. (Enter nature of injury in Part I or Part II of Item 18.) |
| OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| | ACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PL fact while at work at work at work | ory, street, office bldg., etc.) |
| | |
| 21. I certify that (I) (this hospital) attended the deceased from | 1966 to 7.77, 1966 that (1) (we) last |
| saw the deceased alive on | t death occurred at 7 AM, from the causes and on the date stated above. |
| 22a. SIGNATURE | 22b. DATE SIGNED |
| M. M. M. | D. ATTENDING MED. STAFF DIRECTOR PHYS. DI 2.22.66 |
| 22c. PHYSICIAN'S | 22d ADDRESS |
| NAME (Type) AT H Briele | MEMICAL (MIHO) Sandalus Mu |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETER | Y OR CREMATORY 23d. LOCATION (City, town or county) (State) |
| REMOVAL (Specify) | CEMETERY QUANTICO, MARYLAND |
| BURIAL 2/24/1960 QUANTICO 24. FUNERAL DIRECTOR ADDRESS | 1 25a, REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |
| THE PARTY OF THE P | s had a file |
| LEVIN R. WILSON PRINCESS ANNE, M. | o DATE 1 1856 Pelicarles Judge |



| | DIVISION | OF STATISTIC | CAL RESE | ARCH AND RECOR | RDS, 301 W. | PRESTON | STREET, | BALTIMORE | 1, MARYI | AND |
|---------------|---|---|--------------------|--|-------------------|-----------------|------------------|--|-----------------------|-------------------|
| | 02996 | | | CERTIFICA | ATE OF | DEATH | | | 112 | 382 |
| 1. | PLACE OF OEATH a. COUNTY | | | | 2. USUA | | (Where deceas | ed lived, if instituti b. COUNTY | ion: Residence | before admission) |
| | | Wicomico | | MARYLANI | | | rvland | D. GOUNT | 7.73 | _ t |
| | b. CITY OR TOWN | (If outside corporated give nearest tow | te limits, | c. LENGTH OF STAY IN | | R TOWN (If o | outside corpor | ate limits, write R | Wigor URAL and glv | re nearest town) |
| | Salisb | | | 20 Days | li li | Salish | 311797F | | | 1 |
| _ | d. NAME OF HOSE | PITAL OR INSTITUTIO | ON (If not in he | ospital, give street addre | es) d. STREE | T ADDRESS | JUL Y | | 1 6 | . IS RESIDENCE |
| De | | i State Ho | | Salisbury .Md | | | ings St. | | | ON A FARM? |
| 3. | NAME OF | FI | rst | Middle | Las | A A A COLO CO | 4. OATE | Month | Day | Year |
| • | OECEASEO | | | | | an. | OF | 13 - 1- | - | 10// |
| | (Type or print) | Mary | | Frances | Shore of Shore of | S Gr. | g goeath | Feb. | - 6 | 1966 |
| 5. | SEX | 6. COLOR OR RACE | 7. MARRIEO | NEVER MARRIED | | A - | | GE (In years IFUN ast birthday) Mon | TOER 1 YEAR | |
| | Female | White | WIOOWEO | | | 3/189 | 2 1 7 | /3 yrs. 0 | - 5 | |
| 10a dur | I. USUAL OCCUPATI Ing most of workin | ON (Give kind of work g life, even if retire | done 10b. K | NO OF BUSINESS OR NOUSTRY Operator- | 11. BIRT | HPLACE (COL | unty & State, or | foreign country) 1 | 2. CITIŽEN COUNTRY | 7 |
| | | | (Macn. | Operator- | | | | e Ma | USA | |
| | FATHER'S NAME | | | | | HER'S MAIOE | | | | |
| | | lessick | | | | | essic | Messic | k | |
| 15 (Ye | . WAS DECEASED EN | ER IN U.S. ARMEOFO | RCES? 16. | SOCIAL SECURITYNO. | 17. INFORMAN | Con Id | Chames | Address | \D 0 | p #ha |
| ``] | NO | /ER IN U.S. ARM EOF C If yes give war or dates o | 1 30,770 | 1, | Q12 C | Diaman | Puones | Sallsb | JF . U. | arvland |
| _ | | | | Ine for (a), (b), and (c).1 | DIE D. | DIATE | TOR SI | Daliso | ULY SITE | RVAL BETWEEN |
| | | | | ille for (a), (b), and (c). I | | | | | ONS | ET AND DEATH |
| | PART I. DEA | TH WAS CAUSED BY IMMEDIATE CAUSE | | eralized Caro | inomato | sis | | | 1 | Yearl |
| -1 | 1740 | , | .,, | | | | | | | • |
| | Conditions, If a | | Dow | 07000 07000 | | | | | | |
| | gave rise to | | (b) Fall | creas or ov | ary | | | | | |
| | cause (a), sta | | TO | | | | | | | |
| | underlying cause | | (c) | | | | | | | |
| Š | PART II. OTHER SI | GNIFICANT CONDITION | | TING TO DEATH BUT NOT | RELATED TO THE | TERMINAL DI | SEASE CONDIT | TION GIVEN IN PART | 1(a) 19. | WAS AUTOPSY |
| A | | | | | | | | | WE | PERFORMEO? |
| 음 | | | | | | | | | | SYPA NO |
| CERTIFICATION | OR CONTRIBUTION (IF EITHER, NOT) | VAS UNOERLYING [] IG [] CAUSE OF OEA FY MEDICAL EXAMI | (TH NER) 20b. (| DESCRIBE HOW INJURY O | OCCURRED. (Ent | er nature of | injury in Part | I or Part II of Ite: | m 18.) | |
| | | JURY Month, Day, | | NJURY OCCURRED 20e. | PLACE OF INJU | DV Aloma for | CON | ty or town) | (County) | (State) |
| 2 | Hour a.m. | | | | actory, street, o | ffice bldg., et | C.) | ty or town) | (Gounty) | (atace) |
| MEDICAL | p.m | | While at work | Not While | | | | | | |
| - | 21 Leogtifu | that (I) (thin has | heatte fletin | ed the deceased from | 7/70 | 7 10 | 66 to 2 | 2/6 1 | 10 66 # | nat (I) (we) last |
| | | | 2/6 | | | 1 10 | 000 | the causes and | | |
| | | eased alive on | | 19 | that death oc | curred atz. | SSZM, Trom | | b. DATE SIG | |
| | 22a. SIGNATUR | 11 | 1 | | S TTFALC | 1862 N | IED | | | |
| | | V | , he | man | M.D. PHYS. | D | IED. | STAFF PHYS. | 2/7/66 | 5 |
| | 22c. PHYSICIAN | | | | 22d. | ADDRESS | | | | |
| | NAME (Typ |)e) | VV. J | uerman, M. D | Deer | 's Hea | ad State | Hospital | L,Sali | sbury, Md. |
| 23a | BURIAL, CREMA | TION, 23b. OATE | THEREOF | 23c. NAME OF CEME | TERY OR CREMA | TORY | 23d. LOCA | TION (City, town o | or county) | (State) |
| | PHYMIST | reb.9/ | | Parsons | Cemete | rv | Sali | sbury, M | aryla | md |
| 24 | . FUNERAL DIREC | TOR | | ADDRESS | | 1 25a. REC | D BY REGISTE | RAR 25b. REGIS | TRAR'S SIGN | ATURE |
| | | | V CAT | | OVT AND | | | 0001 | | |
| П | OLLOWAY | & COMPAN | T DAI | LISBURY, MAI | TILAND | OATE B | 10 196 | ob filla | rely to | roge |
| | | | | | | | | U | 0 | 0 |

Item 18 Film G373 2/ MARYLAND STATE DEPARTMENT OF HEALTH

VR A15 (4)



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH and 2 death death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. COUNTY within 72 hours after MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b c. CITY OR NAME OF HOSPITAL DR INSTITUTION (if not in hospital, give street address) filled in e. IS RESIDENCE ON A FARM? d. STREET ADDRESS NO P YES completely carbon NAME OF Middle First Last DATE Month Day DECEASED event, 1966 (Type or print) DEATH. AGE (In years | IBUNDER 1 YEAR | IF UNDER 24 HRS. last birthday) | Months | Days | Hours | Min. ешоле 6. COLOR DATE OF BIRTH NEVER MARRIED V Months Days any 9 WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT (County & State, or foreign country) and certificate phy FATHER'S NAME MOTHER'S MAIDEN NAME removal been signed by the attending plant the burial-transit permit. Then it to burial, cremation, or remova 15. WAS DECEASED EVER IN U.S. ARMED FORCES? Address 16. SOCIAL SECURITY NO. INFORMANT (Yes, no. or unknown) i (If yes nive war or dates of service) 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: O HESPITAL OR NITERIORS PRIMILING The lam mulines that the Page 4 may be retained by the hospital or attending plysician. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which (b) gave rise to immediate 書き **DUE TO** cause (a), stating underlying cause last, as in (c) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY for use Health PERFORMED? certificate NO I YES 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) DIRECTOR: After this certage 3 should be detached led with the State Dept. of MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d, INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, Office bldg., etc.) Hour a.m. While Not While at work at work p.m 0 21. I certify that (1) (this hospital) attended the deceased from saw the deceased alive on ZM. from the causes and on the date stated above. and that death occurred at a DATE SIGNED 22a. SICNATURE 22b. ATTENDING & TO FUNERAL DIRE director, page 3 should be filed w MED. DIRECTOR 6 M.D. PHYSIC AN'S 22d. ADDRESS 22c. NAME (Mype) BURIAL, CREMATION, 1 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State) 23c. 23d. REMOVAL (Specify) DELLAR PUNERAL DIRECTOR **ADDRESS** 25a. - REC'D BY-REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 15M 4-64



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2/ and 2 death hours after death 1. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY b. COUNTY completely filled in by the f ve carbon papers. Pages 1 event, within 72 hours after WICOMICO MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b Salisbury (Rural) ALLS BURY d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS R.D.# executed within NAME DE Frederick Middle DATE Last 4. Month grick Ernest Geo. (Type or print) BR DEATH AGE (In years | IF UNDER 14 EAR | IF UNDER 24 HRS remove 7. MARRIED 🔀 NEVER MARRIED 🛚 last birthday) Months and any 18/1924 July WIDOWED T DIVORCED T Ð 10a. USUAL OCCUPATION (Give kind of workdone) 10b. KIND OF BUSINESS OR during most of working ilfe, even if retired) INDUSTRY ≘ 11. BIRTHPLACE (County & State, or foreign country) HÇjan nding physician Then, please I removal and in death certificate be City Administrator(Manager) Pocomoke Bridgeport, Conn. 13. FATHER'S NAME MOTHER'S MAIDEN NAME Helen Tearne attending a Frederick George Ermest Heyse Mrs. Nancy 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. C. Heyse (Wife) R.D.#1 FUNERAL DIRECTOR: After this certificate has been signed by the atten irector, page 3 should be detached for use as the burial-transit permit. nould be filed with the State Dept, of Health prior to burlal, cremation, or a Yes, no, or unkown) ([fyes give war or dates of service)
Yes W. W. #II(Navy Salisbury, Maryl 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OR ATTENDING PHYSICIAN: The law requires that tile be retained by the hospital or attending physician. DUE TO Conditions, if any, which (b) gave rise to immediate DUF TO cause (a), stating the underlying cause last. (c) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part 1 or Part II of Item 18.) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 208, PLACE OF INJURY (Home, farm, 20f. (Clty or town) factory, street, office bldg., etc.) Hour a.m. While Not While at work at work 3-79 2-1 21. I certify that (I) (this hospital) attended the deceased from 19. 93 M, from the causes and on the date stated above. saw the deceased alive on and that death occurred at. 22b. DATE SIGNED 22a. SIGNATURE Feb.2/1966 DIRECTOR T M.D. Page 4 may ! 22c. PHYSICIAN' 22d. **ADDRESS** director, p should be 1 Fruitland. Maryland DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) BURIAL, CREMATION, 23b. REMOVAL (Specify) 2 Arlington National Cemi Arlington, Virginia 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS SALISBURY MARYLAND HOLLOWAY & COMPANY 1966

e. IS RESIDENCE ON A FARM?

19

Hours

INTERVAL BETWEEN

ONSET AND DEATH

WAS AUTOPSY PERFORMED?

NO E

(State)

(State)

MIN

YES T

1966, that # (we) last

(County)

12. CITIZEN OF WHAT

COUNTRY? SA NOT

YES

τ

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 10000 1600 funeral and 2 death. death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. COUNTY b. COUNTY a. STATE Wicomico ges 1 Maryland Wicomico MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pag nours Days Salisburv Salisbury filled in d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE completely filled ye carbon papers. d. STREET ADDRESS ON A FARM? 318 Boulden NO Deer's Head State Hospital, Salisbury. Md. executed within NAME DE First Middle Month Day Year Last DECEASED 1966 DEATH (Type or print) Hicks Feb. erman AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. 5. SEX 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED | NEVER MARRIED last birthday) Months Days Hours Male Negro WIDOWED DIVORCED 12. CITIZEN OF WHA 10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fereign country) been signed by the attenting "lysician" the burial-transit permit. Then grease or to burial, cremation, or removal. The law requires that the death certificate be COUNTRY? during most of working life, even if retired) INDUSTRY Long 13. FATHER'S NAME MOTHER'S MAIDEN NAME 14. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? Address 16. SOCIAL SECURITY NO. 17. INFORMANI (Yes, no, or unknown) (UFTEs give war or dates of service) INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease or attending physician. DUE TO Arteriosclerosis, general Years Cenditions, If any, which (b) gave rise to immediate DUE TO cause (a), stating underlying cause last. has as (c) CERTIFICATION WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) for use Health this certificate by detached for use te Dept. of Health PERFORMED? YES NO Y 20a. ACCIDENT WAS UNDERLYING (20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part | or Part | of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) TIME OF INJURY Month, Day, Year Page 4 may be retained by the TO FUNERAL DIRECTOR: After the director, page 3 should be de should be filed with the State I factory, street, office bldg., etc.) be de State Hour a.m. While Not While 19 at work at work p.m. 66 21. I certify that (I) (this hospital) attended the deceased from and that death occurred at 6:30%, from the causes and on the date stated above. 66 saw the deceased alive on 22a. SIGNATURE 22b. DATE SIGNED MED. DIRECTOR M.O. PHYS. 22c. PHYSICIAN'S ADDRESS NAME (Type) Juerman, M.D. Deer's Head State Hospital Salisbury Md 23d./LOCATION (City, town or county) 23c. LNAME OF CEMETERY OR CREMATORY (State) 23a BURIAL, CREMATION, 23b REMOVAL (Suchify) 253 REC'D BY REGISTRAR 25h REGISTRAR'S SIGNATURE FUNERAL DIRECTOR **ADDRESS** 24. VR AI5 (4) DATE 20M 1/65

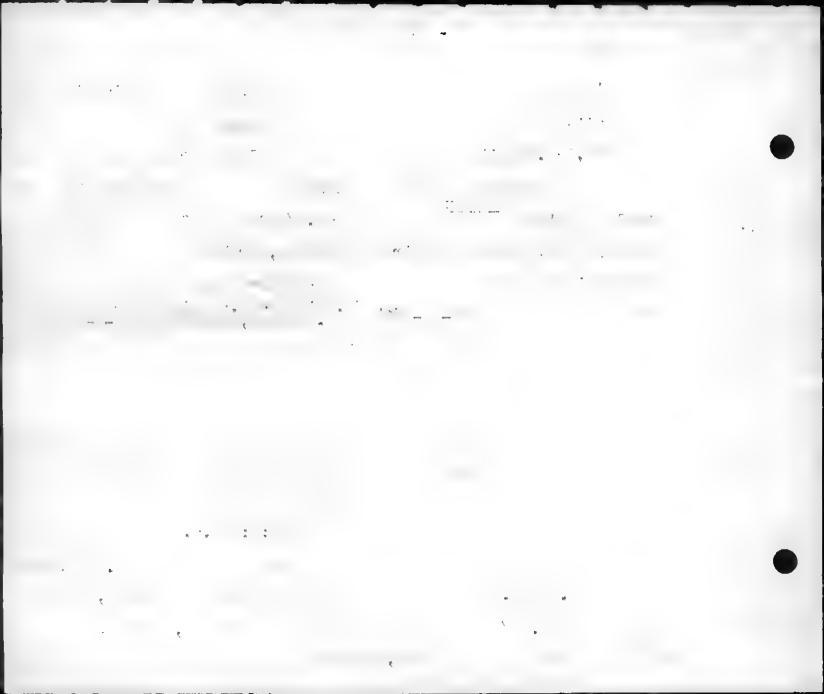
) ren

Tage 4 may be retailed by the inspired by the attending physician are completely filled in by the funeral GINERAL DIRECTOR: After this certificate has been signed by the attending physician are carbon papers. Pages T and 2 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages T and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours afterdeath. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

| 1. PLACE OF DEATH | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) |
|--|---|
| a. COUNTY. Wicomico | a. STATE MO 3 Company b. COUNTY 74 Company aumissions |
| MARYLAND 1 | a. STATE Maryland b. COUNTWICOMICO |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| Salisbury | Hebrom / |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | d. STREET ADDRESS e. IS RESIDENCE |
| Pen.Gen.Hospital | Walnut Street ON A FARM? YES □ NO 3 |
| 3. NAME OF First Middle DECEASED | Last 4. DATE Month Day Year |
| (Type or print) ELNORA ELLEN | HOPKINS DEATH FEBRUARY 10 19 66 |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8 | B. DATE OF BIRTH 19. AGE (In years LEUNDER 1 YEAR HELINDER 24 HRS |
| Female White WIDOWED DIVORCED] | Mar. 4/1892 Past birthday Months Days Hours Min. |
| 10a, USUAL OCCUPATION (Give kind of workdone 10b, KIND OF BUSINESS OR during most of working life, even if retired) INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? |
| Grocery Store Owner - Retired | Hebron, Maryland USA |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
| Henry Phippin | Josephine Humphreys |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. (Yes, no, or unknown) (If yes give war or dates of service) | Clifford J. Hopkins (Husband) Walnut |
| NO 212-10-2694 | St. Hebron, Maryland (PI 9.3903) |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | INTERVAL BETWEEN |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILIABY C | 1 BB HOSIS ONSET AND DEATH 3 MON S |
| .014 | 1 17BHOSIS 3MONS |
| Conditions, If any, which | |
| gave rise to immediate (b) | |
| cause (a), stating the DUE TO | |
| underlying cause last. (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED | TED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(2) 19. WAS AUTOPSY PERFORMED? |
| ICA I | YES NOT |
| ZOa. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCUI | RRED. (Enter nature of injury in Part I or Part II of Item 18.) |
| (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| | E OF INJURY (Home, farm, 20f. (City or town) (County) (State) |
| Hour a.m. While Not While factor | y, street, office bldg., etc.) |
| | 1/3 -66 - 3/10 -2/10 |
| 21. I certify that (I) (this hospital) attended the deceased from | ADD: 19.2.50 M., 19.6./., that (I) (we) last |
| saw the deceased alive on 2 // 0 19 66, and that | |
| 223. SIGNATURE | ATTENDING MED. STAFF PAR 12 13 066 |
| John In Ostorion -111 M.D. | PHYS. A DIRECTOR PHYS. FCD. / 3 / 1900 |
| 22c. PHYSICIAN'S NAME (Type) | 22d. ADDRESS |
| 22c. PHYSICIAN'S NAME (TYPE) TO TO THE BLOOM 23a. BURIAL, CRÉMATION, 23b. DATE THEREOF 1 23c. NAME OF CEMETERY | Medical Center Salisbury, Maryland |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY | OR CREMATORY 23d. LOCATION (City, town or county) (State) |
| Burial Feb. 13/1966 Hebron Ceme | tery Hebron, Maryland |
| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |
| HOLLOWAY & COMPANY SALISBURY, MARYI | AND DATE B 1 5 1966 Michaeles Judge |
| Property of the state of the st | MIND DATE B 15 1950 1 Carely July |

VR A15 (4) 20M 1/65



MARYLAND STATE DEPARTMENT OF HEALTH

funeral hours after death by the tu carbon papers. Pages 1 ent, within 72 hours after filled in and completely death certificate be executed within lease remove and in amy ermit. Then please results on, or removal, and in certificate has been signed by the atten hed for use as the burial-transit permit. t. of Health prior to burial, cremation, or i D HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Page 4 may be retained by the hospital or attending physician. as FUNERAL DIRECTOR: After this certificator, page 3 should be detached frould be filed with the State Dept, of director, p should be 1 2 VR A15 (4)

. क्यांचक्र कर

| FOR STATE | | 33002 MEDICAL EXAMINER'S | CERTIFICATE OF DEATH | 02988 |
|--|---------------|--|--|---|
| EALTH DEPT. 프무용 호텔 | | PLACE OF DEATH COUNTY Wicomico MARYLAND | USUAL RESIDENCE (Where deceased lived if institution Resider O. STATE Maryland b. COUNTY W | nce before admission) |
| 1, 2, and 3 The PM3. Page Department is after seat | | b CITY OR TOWN (If autside corporate limits, c LENGTH OF STAY N 1b write Bear or swe pagest town) | c. CITY OR TOWN (If outside corporate limits write RURAL and give Sharptown | e nearest tawn) |
| ges 1, 2, 1 farm P farm | | d NAME OF HOSPIAL OR INSTITUTION (If not in hospital give street oddress) Peninsula General Hospital | d STREET ADDRESS | e IS RESIDENCE ON A FARM? YES NO |
| Po Po With With 72 72 | | NAME OF First Middle DECEASED (Type or pnnt) Donald Lee Robe | Lost HUTTERN DEATH 2-19-66 | Day Year |
| 18. Give | 5. | | DATE OF BIRTH 1-6-1955 9 AGE (In years IF UNDER lost by the day) Months | 1 YEAR IF UNDER 24 HRS |
| 1 24 haurs I in Item II er's Office ges I and Z any event | 10o dur | LSUAL OCCUPATION (Give kind of work done ng most of working lite even first real) (NDUSTRY | | TIZEN OF WHAT |
| | 13 | FATHERS NAME /17/01 Hutton | 14 MOTHERS MAIDEN NAME Blawn | / |
| xecured winding" in perfect that the permit free movel, and | | WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give wor or dotes of service) 16. SOCIAL SECURITY NO 17. If | resphilat Reins Sur | Polus, MA |
| pe execution "pending" "pending" nef Medica ansit permitation or remaya | | 18 CAUSE OF DEATH (Enter only one couse per line for (g), (b), ond (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE (AUSE (g) ASPhyxia | | INTERVAL BETWEEN ONGEL AND DEATH SUGGER |
| shauld he ward to the Cl burial-fra mation, | | Conditions, if ony, which gove nise to immediate couse (o). | | Sudden |
| S de S | | kost (c) | THE TENER AL DIFFECT CONDITION CAPE A DROT VA | 19 WAS ALTOPSY |
| nis crite, at far be u to b | CERTIFICATION | PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO TI | | PERFORMED? YES NO X |
| certifice could be es. thauld I priar | | PRIMARY I or CONTRIBUTING Playing with r | (Enter notive of njury n Port I or Port II of tem 18) cope in tree and hanged himsel | |
| te the ge 4 sh your fill ogent | MEDICAL | 20c TIME OF INJURY Month Doy, Year 3:50 op att 2-19-66 | ord area. Sharptown Wicomi | |
| ise execut se execut ectar. Pag ined far y RECTOR: P esignated | | 21. I certify that I took charge of the remains described above, held death resulted from Natural causes,AccidentA. Soice | | and in my opinic |
| pled dir dir dir dir dir dir dir dir dir di | | ACTUAL SIGNATURE & L | CHIEF MEDICAL EXAMINER | 22. DATE SIGNED |
| necessary, the funeral 5 may be Coruneral Health ar r | | EXAMINER'S Earl L. Royer, M.D. Name (Type) 1,09 Camder Ave. Salisbury, Md. | DEPUTY MEDICAL EXAMINER 2-21- Address (Street city town, or county) | |
| TO Fig. | 230 | | www 1 Med Wellome | |
| VR A15ME (5) | | rineo B. Washell Easts. | 250 RECO BY REGISTRAR 256 REGISTRARS: | 194 |



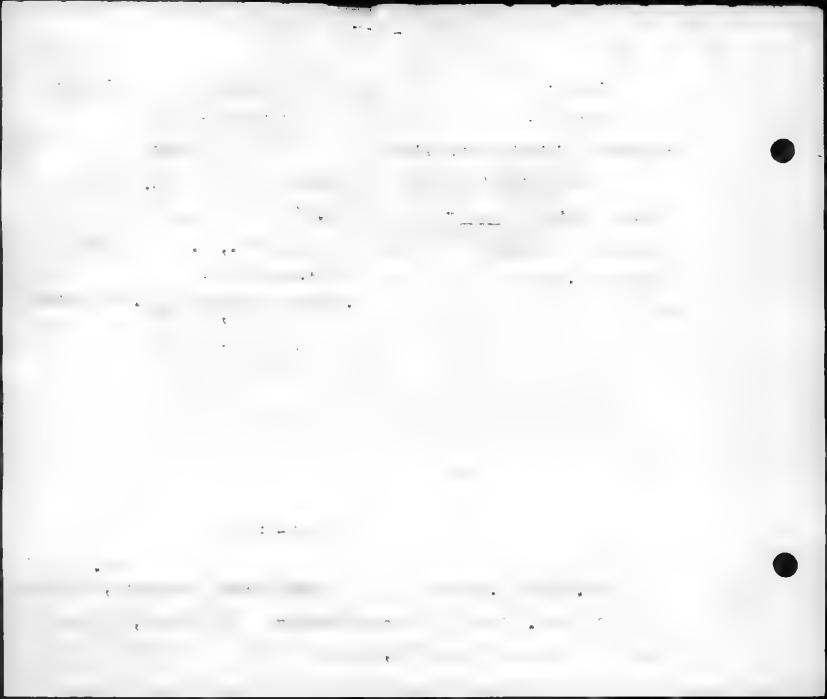
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be elecuted within 24 hours after death, Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burnal-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

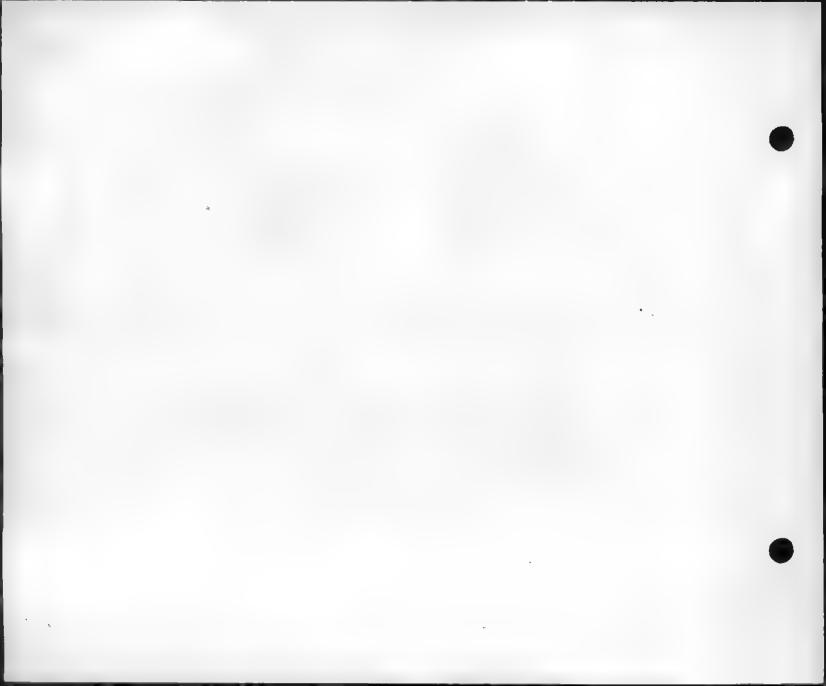
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

| 33005 GERTIFICATI | E OF DEATH 172389 | | | | | | | |
|--|--|--|--|--|--|--|--|--|
| 1. PLACE DF DEATH a. CDUNTY W1COM1CO MARYLAND | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) o. STATEMARYLAND b. COUNTY Wicomico | | | | | | | |
| | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | | | |
| write RURAL and give nearest town) | | | | | | | | |
| Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | Salisbury 1 / | | | | | | | |
| | ON A FARM2 | | | | | | | |
| Springhill Private Samitarium | OD Park Avenue YES NO | | | | | | | |
| 3. NAME DF First Middle | Last 4. DATE Month Day Year | | | | | | | |
| (Type or print) MARY SUSAN (MOLLIE) | INDUEL DEATH FEB. 28th 1906 | | | | | | | |
| 1. maddles nettly modules | 8. DATE OF BIRTH 9. AGE (in years FUNDER 1 YEAR FUNDER 24 HRS. last birthday) Months Days Hours Min. | | | | | | | |
| | 86 yrs. | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INDUSTRY | 11. BIRT HPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT | | | | | | | |
| House wife at home none | Accomac Co., Va. UCDUNTRY? | | | | | | | |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | | | | | | | |
| Johannas L. Byrd | Elizabeth Parks | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. | Kerns Mears (Son) 734 dors Park Drive | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (16. SOCIAL SECURITY NO. 17. (1f yes give war or dates of service) | Salisbury, Maryland | | | | | | | |
| [18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] | INTERVAL BETWEEN | | | | | | | |
| PART I, DEATH WAS CAUSED BY: | decemplusation ONSET AND DEATH | | | | | | | |
| Thim Edial E GAOSE (a) | | | | | | | | |
| Conditions, If any, which DUE TD Ordered solution least design | | | | | | | | |
| gave rise to immediate | | | | | | | | |
| cause (a), stating the DUE TD | | | | | | | | |
| underlying cause last.) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA | ITED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 119. WAS AUTOPSY | | | | | | | |
| The state of the s | PERFORMED? | | | | | | | |
| an contrat was unprovided in a proposed they will be a | YES NO X | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCU BY CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDIBAL EXAMINER) 31 / 1 | JRRED, (Enter nature of injury in Part 1 or Part II of Item 18.) | | | | | | | |
| | | | | | | | | |
| Species | CE OF INJURY (Home, farm, 20f. (City or town) (County) (State) | | | | | | | |
| | | | | | | | | |
| | 10605+ 1951, to Feb. 28, 1966, that (1) (we) last | | | | | | | |
| saw the deceased alive on 2-7. 1966, and that | death occurred at 40PM, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATIONE | 22b. DATE SIGNED | | | | | | | |
| The Sta Rester / M.D | | | | | | | | |
| 22c. OHYSTCIAN'S NAME (Type) | 22d. ADDRESS | | | | | | | |
| NAME DE Philip A. Insley | Main Street Salisbury, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY | | | | | | | | |
| | Cometery Salisbury, Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| HOLLOWAY & COMPANY SALISBURY MARY | LAND 1000 1000 | | | | | | | |

VR A15 (4) 20M 1/65



| 1 | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAR | VI AND |
|---|--|---------------------------------|
| = = N | 03004 CERTIFICATE OF DEATH TO THE | 02990 |
| hours after death d in by the funeral rs. Pages 1 and thours after death | 1. PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, if Institution: Reside a. STATE b. COUNTY Word | |
| after the ges 1 after | Wicomies MARYLAND MARYLAND MARYLAND | V |
| in by Pag | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b C. CITY OR TOWN of outside corporate limits, write RURAL and give nearest town) SALS BURGA STOCKEON | 1 |
| vithin 24 hours after letely filled in by the chon papers. Pages , within 72 hours after | d. NAME DF HDSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS | e. IS RESIDENCE ON A FARM? |
| hin tely for power within | 3. NAME OF First Middle Last 4. DATE Month D | YES NO Vear |
| d with | (Type or print) Adaline P. Johnson BEATH FOBRUARY | 19 19 66 |
| executed within and completely in remove carbon p | 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IFUNDER'TYE last birthday Months Day | AR IF UNDER 24 HR: Hours Min. |
| | | EN OF WHAT |
| ysicia pleasi | house wite HECOMACK, VA, VS | A |
| tiffica ng ph hen noval | 13. FATHER'S NAME 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 14. MOTHER'S MAIDEN NAME 17. F. PORKS 18. MOTHER'S MAIDEN NAME | |
| eath certific attending p ermit. Then on, or remov | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) ((fyesgive war or dates of service) | · v.T.N. |
| e death the atter t permit ation, or | NO 230-14-8/84 MAS LuThen Tauiti In Slo | NTERVAL BETWEEN |
| hat the deal clan. led by the a' l-transit perr l, cremation, | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROPERTY OF THE PROPERTY OF | DISET AND DEATH |
| that ysiclar gned ial-tra ial, cr | DUE TO | |
| ding phydding phyben sl been sl the bur ir to bur | Conditions, if any, which (b) (b) gave rise to immediate (c) DUE TD | |
| law requires that attending physician is has been signed is a stee burial-train prior to burial, c. | underlying cause last, (c) | |
| | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | PERFORMED? YES NO |
| CIAI Spiral Cert cert hed L of | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| PHY Epster | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work at work at work | (State) |
| | 21. I certify that (I) (this neepttal strended the deceased from \\26 // 19 do, to \tab. 19, 19 66, | |
| ATT reta reta 3 sho with | saw the deceased alive of 1966, and that death occurred at 6 M, from the causes and on the causes are caused by the caused by the causes are caused by the | date stated above Signed |
| RL OR say be page filled | M.D. ATTENDING MED. STAFF DIRECTOR PHYS. | |
| Page 4 may Page 4 may FUNERAL I director, pag | 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS | |
| TO HOSPITAL OR ATTENI Page 4 may be retaine TO FUNERAL DIRECTOR: director, page 3 shoul should be filled with the | 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county | (State) |
| | 24. FUNERAL DIRECTOR ADDRESS 250. REGISTRAR 250. REGISTRAR'S S. | MATURE |
| VR A15 (4) 15M 4-64 | Henry M. Johnson DATE 2/21/66 | |
| 40m T-07 | FEB 23 1936 flanles & | udge |



OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral apd-2 hours after death PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY a. STATE b. COUNTY TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f director, page 3 should be detached for use as the burial-transit permit. Then please temos carbon papers. Pages 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after MARYLAND b. CITY OR TOWN (If outside corporate ilmits, c. CITY OR TOWN (If outside corporete limits, write RURAL end give nearest town) c. LENGTH OF STAY IN 1b write RURAL end give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) executed within NAME OF Month First DATE Middle 4. OF DEATH **OECEASEO** (Type or print) nson AGE (In years | IF UNDER 1 YEAR | FUNDER 24 HRS. | last birthday) | Months | Days | Hours | Min. 6. COLOR OR RACE DATE OF BIRTH 9. 8. 7. MARRIED NEVER MARRIED 7 33 ,1932 DIVORCEO P Augus t 9 WIOOWEO negro YES 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHA 10a, USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR O HOSPITAL OR ATTENDI WYS TO THE faw requires that the death certificate be Page 4 may be retained by the hospital or attending physician. COUNTRY? INOUSTRY during most of working life, even if retired) Domestic Maryland A 13. FATHER'S NAME 14. MOTHER'S MAJOEN NAME Clarisa John Johnson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address (Yes, no. or unkown) (If yes give war or dates of service) No Johnson Juantico Box Leonard INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). ONSET AND DEATH 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Lescon Conditions, if any, which (b) rise to immediate DUE TO cause (a), stating underlying cause last. (c) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part 1 or Part 1) of Item 18. 20a. ACCIDENT WAS UNDERLYING I OR CONTRIBUTING TI CAUSE OF GEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d, INJURY OCCURRED 120e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. While Not While 27/ 66 at work at work p.m. 19 21. I certify that (I) (this hospital) attended the deceased from 2.M. from the causes and on the date stated above. and that death occurred at 2 saw the deceased alive on DATE SIGNED 22b. 22a. SIGNATURE **ATTENDING** STAFF PHYS. M.D. DIRECTOR PHYS. PHYSICIAN'S 22d. ADDRESS Medical Center, Sal isbury. Wilber Ellis. Jr., M.D BURIAL, CREMATION, REMOVAL (Specify) NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23b. DATE THEREOF «uantico FUNERAL DIRECTOR ADDRESS REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH

e. IS RESIDENCE ON A FARM? No.

Year

WAS AUTOPSY

(State)

Md.

(State)

PERFORMED? NO)

YES

19



MARYLAND STATE DEPARTMENT OF HEALTH

15M 4-64



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

| | 1 | KHI KA | | | CERTIFICAL | E OF DEA | ATH | | 82993 | |
|-----|---------------|--------------------------------------|---|-----------------|----------------------------|----------------------------|------------------------|---------------------|--|-----------------|
| VI | JE. | PLACE OF GEAT | Н | | | 2. USUAL RES | IOENCE (Where decease | | ion: Residence before ada | nission) |
| | - | a. COUNTY W1 | comico | | MARYLAND | a. STATE | Maryland | b. COUNTY | icomico | |
| | | b. CITY OR TOW | N (if outside corporate | limits, c | LENGTH OF STAY IN 1b | c. CITY OR TOV | N (If outside corpor | ate limits, write R | URAL and give nearest | town) |
| | | W1 | N (if outside corporate and give nearest town) | | | | Willards | | 22-1 | |
| | | d. NAME OF HO | SPITAL OR INSTITUTION | (if not in hosp | ital, give street address) | d. STREET ADD | | | 8. IS RESI | OENCE |
| ^ | | | D.# 1 | | | | R.D.# 1 | | | NO . |
| | 3. | NAME OF OECEASEO | Firs | | Middle | Last | 4. DATE | Month | Oay Year | |
| | _ | (Type or print) | ELIZA | BETH | E. | JONES | DEATH | FEB. | 24 196 | |
| | 5. | SEX | 6. COLOR OR RACE 7 | MARRIED K | LIGEACY WINKERIED | 8. DATE OF BIRT | | GE (In years IFU | NGER 1 YEAR IF UNDER | 24 HRS. Min. |
| | | Female | White | WIDOWEO | | Jam.J.2/3 | 1892 7 | 4 yrs. | 1 12 | 1014174 |
| | dur | a. USUAL OCCUPAT Ing most of work | ION (Give kind of work do ing life, even if retired) | ne 10b. KIND | OF BUSINESS OR | 11. BIRTHPLAC | CE (County & State, or | foreign country) | 12. CITIZEN OF WHAT COUNTRY? | |
| | | HOUSE M | 110 | nene | | | ville, Mar | yland | U S A | |
| | | . FATHER'S NAW | | | | 14. MOTHER'S | | | | |
| | | | H. Bethard | | | Sall | le Calla | | | |
| | 15 (Ys | . WAS OECEASEO | EVER IN U.S. ARMED FOR | erwice) | CIAL SECURITY NO. 17 | INFORMANT P.F. P. P. S. | Tones | (Husban | 4)R.D.# 1 | |
| |] | No | (If yes give war or dates of s | 214 | -36-5502 " | Willa | rd. Mary | land | w/1140/6// 1 | |
| | _ | | DEATH [Enter only one | | for (a), (b), and (c).] | | / *- | | INTERVAL BETY | |
| | | PART I. DE | | ONSET AND DI | 19 | | | | | |
| | | 14= | DUE TO | | 1 . 1 | | - | | | |
| | | Cenditions, If | any, which | beld to | interest of | k. | | | | |
| | | gave rise to cause (a), s | Immediate (| 11 | 2 . 0 | | | | | |
| | | underlying caus | | , art | a ricellar | res | | | | |
| | CERTIFICATION | PART II. OTHER | | | NG TO DEATH BUT NOT RELA | TED TO THE TERMI | NAL DISEASE CONDIT | ION GIVEN IN PART | 11(a) 19. WAS AUT PERFORM | |
| je. | ICAI | | | | | | | | | NO T |
| | ΞÏ | 20a. ACCIOENT | WAS UNDERLYING | 20b. OES | CRIBE HOW INJURY OCCU | JRRED. (Enter natu | ire of injury in Part | I or Part II of Ite | the same of the sa | |
| 1 | CEF | (IF EITHER, NO | WAS UNDERLYING THE CAUSE OF DEATH OF MEDICAL EXAMINE | R) N/ | 'A | | | | | |
| 1 | CAL | | INJURY Month, Oay, Ye | ar 20d. INJU | RY OCCURRED 20e. PLA | CE OF INJURY (Ho | me, farm, 20f. (CI | y or town) | (County) (St | late) |
| | MEDICAL | Hour a.r | | While at work | Not White Tacto | ry, street, office b! | og., etc.) | | | |
| | 45 | | | | the deceased from / | 71.0 | ., 19 to_2_ | -24 | 1966, that (1) (we | o) last |
| | | | ceased alive on | 2/- : | 1966 and that | death occurred | Pat 7 Am. from | | on the date stated a | |
| | | 22a. SICHATUI | | 1 | | | | | b. DATE SIGNEO | |
| | | C. J. | KUKSTIS | eved | M.D | ATTENDING D | MEO, DIRECTOR | STAFF FHYS. F | eb. 78/19 | 66 |
| / | | 22c. PHYSICIA | N'S | | | 22d. ADORE | SS | | 7 - 2 | |
| | | NAME D | r.FrankR.I | ewis | , | Willa | rds, Mary] | end | | |
| | 23a | BURIAL, CREM | ATION, 23b. DATE TH | EREOF 2 | 3c. NAME OF CEMETERY | OR CREMATORY | 23d. LQCA | TION (City, town | or county) (Sta | te) |
| 1 | | Burial (Soc | Feb.27/ | 1966 N | t.Plessant | Cemete | ry R.D.# | Willar | ds, Maryla: | nd |
| | 24 | . FUNERAL OIRE | CTOR | | AOORESS | 25a. | REC'D BY REGISTA | AR 25b. REGIS | TRAR'S SIGNATURE | |
| N | | HOLLOWA | Y & COMPAN | Y SAI | LISBURY, MAR | YLAND DAT | E |) ,, | 11 . * = | |

TO FUNERAL CHRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remark carbon pagers. Rages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO SERITAL OF LITERORIGE FAYS. AT The law requires that the leath certificate be Page 4 man like retained by the hospital or attending physician. VR A15 (4) 20M 1/65

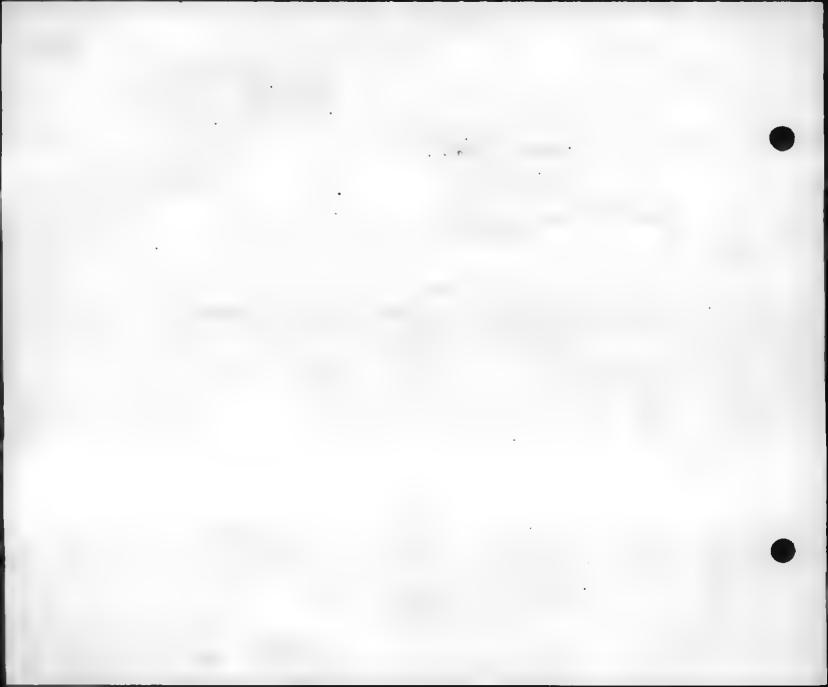
td within 24 hours after death.

· Q · · · ₹

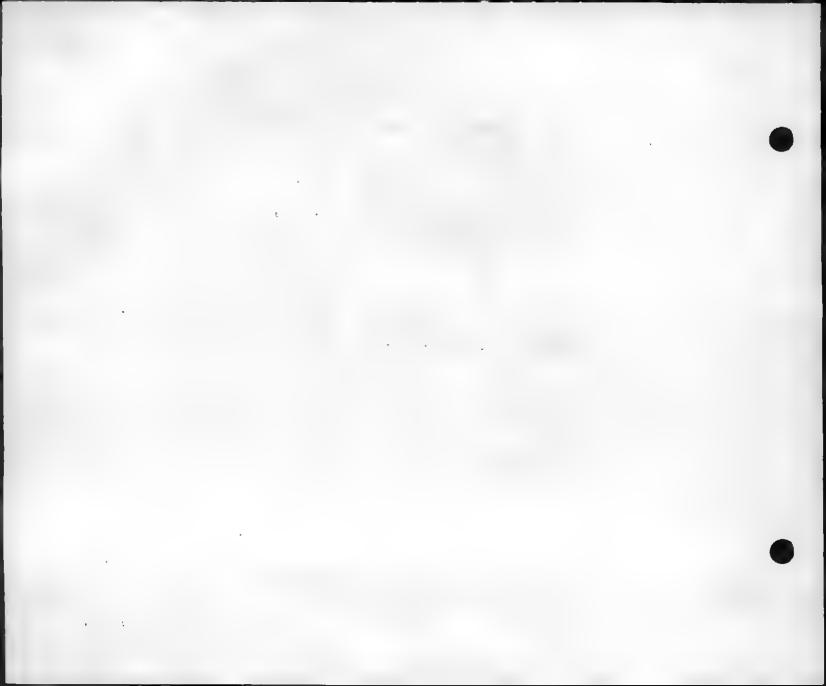
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their prease remove carbon papers. Pages 1 and 2 should be miled with the State Dimit. If Health mile to Dimit, or removal, and in any event, within 72 hours after peach. 24 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

| ı | | 03083 CERTIFICATI | E OF DEATH | 112334 |
|---|-------------|---|--|--------------------------------|
| | | PLACE OF DEATH a. COUNTY | 2. USUAL RESIDENCE (Where deceased lived, if institution: Re a. STATE a b. COUNTY | sidence before admission) |
| 1 | _ | b. CITY OR TOWN (If outside corporate limits, I c. LENGTH OF STAY IN 1b | C. CITY OR TOWN (If outside corporate limits, write RURAL | and give nearest town) |
| 1 | (| write RURAL and give nearest town) | Priveess Aure | , , |
| | 0 | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | d. STREET ADDRESS | e. IS RESIDENCE ON A FARM? |
| | 10 3. | NAME OF FIRST MIDDLE | Last 4. DATE Month | Day Year |
| 1 | | NAME OF First Middle DECEASED (Type or print) | Jones DEATH February | 16 19 66 |
| | 5. | SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8 | B. DATE OF BHATH P 9. AGE (In years IF UNDER I | |
| ı | 100 | male Negre WIDOWED DIVORCED / | 7 8 4 1 yrs. 871 | TYZEN OF WHAT |
| ı | duri | Ing most of working life, even if retired) INDUSTRY | | UNTRY? |
| | 13. | FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | 7/1 |
| i | | HERRY BYRD | MARY CARR, | |
| | | . WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. 19, no, or unknown? (If yes give war or dates of service) | INFORMANT Address | · In .1 |
| | i | 18. CAUSE OF DEATH [Enter only one cause per line / [Fr (a), (b), and (c),] | Effactio Jones Princeso | INTERVAL BETWEEN |
| | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | 15t ade Hemplena | ONSET AND DEATH |
| | | 443X DUE TO ALL T | 6115 | Hale |
| | | gave rise to immediate (b) | in C. Pisosse | 1 1 |
| | | cause (a), stating the DUE TO underlying cause last. (c) Litera Sch | lions | iluk |
| | TION | PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA | TED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | 19. WAS AUTOPSY PERFORMED? |
| 7 | CERTIFICATI | Joa. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW WHAT OCCU | DRRED. (Enter nature of injury in Part I or Part II of Item 18. | YES NO 4 |
| | CERT | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | Terror Jacob St. Injury In Care Control of the Cont | Mana 1 |
| | MEDICAL | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLAI | CE OF INJURY (Home, farm, 20f. (City or town) (Courry, street, office bidg., etc.) | nty) (State) |
| | MED | p.m. 19 at work at work | 9= 15 7 11 1 | |
| | Н | 21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1900, and that | t death occurred at 135 M, from the causes and on the | , that (I) (we) last and above |
| | | 22a. SIGNATURE | 22b. 0/ | ATE SIGNED |
| , | | 22c. PHYSICIARYS M.D | ATTENDING A MED. PHYS. STAFF PHYS. 126. ADDRESS | 0-11,1766 |
| | | NAME (Type). Herbert Sembly | dalisbury M. | \mathcal{U}_{i} |
| 1 | 23a | BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMPTERY | OR CREMATORY 23d. LOCATION SCITY, town or cou | nty) (State) |
| | 24. | BURIAL FEB 20166 GRACE | 1 25a, REC'D BY REGISTRAR 25b, REGISTRAR | S SIGNATURE |
| 2 | 1 | Charles HI and Marion | rud TER 23 1988 Literles | Judge |



| 1 | - | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYL | AND |
|--|---------------|--|------------------------------|
| 4 7 | | 83009 CERTIFICATE OF DEATH | 90 |
| death. | 1. | PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if instribution: Residence a. COUNTY b. COUNTY b. COUNTY | before admission) |
| | _ | W. Comico MARYLAND Delaware Suxxes | |
| rs afte by the Pages urs aft | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give | e nearest town) |
| 를 다 '' 현 | - | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS | . IS RESIDENCE |
| filled in 72 h | | To be and RZA. | ON A FARM? |
| ithin 24 th | 3. | Thingsalle Denimin Total | Year |
| within pletely arbon pt, with | . | OF DECEASED (Type or print) Emma Glizate to Jone's DEATH Fit. 16 | 19 66 |
| uted within completely i | 5. | SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (in years IF UNDER 1 YEAR last birthday) Months I Days | |
| and com | 1 | tenale WINITE WIBOWED DIVORCED JEn. 14, 1897 69 yrs. | |
| (= = _ | 1Da dur | a. USUAL OCCUPATION (Give kind of work done 1Db. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN COUNTRY COUNT | OF WHAT |
| 4— 45 — | | Housewire Cwn Home Maryzana OSA | |
| ₩ ,, 55 | 13 | 3. FATHER'S NAME Peter West Elizabeth Hudson | |
| certificate nding phys Then pie removal, a | 15 | 5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address | |
| 도 완품이 | (Ŷĭ | (es, no, or unknown) (if yes give war or dates of service) xx | |
| | | THE CONTRACTOR OF THE CONTRACT | RVAL BETWEEN ET AND DEATH |
| s that the ysician. igned by the ial-transitrial, crema | | PART I. DEATH WAS CAUSED BY: IMMEDIATE GAUSE (a) Inhacerelial Hemoritage. | |
| hysical hysical hysical hysical hysical hysical hysical hybridal h | | conditions, if any, which) bulancachnoid amounting. 24 | his. |
| ding p been the bur or to bu | | gave rise to immediate cause (a), stating the DUE TO | |
| s by se the | | underlying cause last. (c) $H S \in V D$. | |
| atte atte e ha se a th p | TION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. | WAS AUTOPSY PERFORMED? |
| Filestor in Health | FICA | Hypertension - YE | s 🗍 no 🖳 |
| ospil cert hed t. of | CERTIFICATION | | |
| this beta | MEDICAL | 2Dc. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 208. PLACE OF INJURY (Home, farm, lown) (County) Hour a.m. While Not while 100 Miles 10 | (State) |
| Stat part at | MED | P.m. 19 at work at work | |
| 2 8 2 2 3 3 3 | | the try tend to the try tend to the tend t | nat (I) (we) last |
| ith she she | | saw the deceased alive on 2 - 16 1966, and that death occurred at 7/8 M, from the causes and on the dat 22a. SIGNATURE | e stated above. |
| March 217 (20) | | M.D. ATTENDING MED. STAFF 2 1/6 | 166 |
| = R - C - / | | 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS Center Salesbur | 7. M. |
| O HOSPITA Page 4 m D FUNERAL director, 1 should be | 23 | Ba. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) | (State) |
| 5 € € € € € € € € € € € € € € € € € € € | | BOY (Specify) 1/18/66 Dale Whaleyville, Md. | |
| , | 2/ | 4. FUNERAL DIRECTOR 250. REGISTRAR 250. REGISTRAR'S SIGN | ATURE |
| VR A15 (4) | 1 | Tiler / Maly Sellywille def, DATE B 18 1966 Marla Ju | edge |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and in property filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remote carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

| J | 0381 | 0 | CERTIFICATI | E UF DEATH | | | 0~30(|) |
|---|---|--|-------------------------------|------------------------------|--------------------------|---|--|------------------|
| 7 | 1. PLACE OF DEAT | H | | 2. USUAL RESIDENC | E (Where deceased live | d, If institution: Re | esidence before admi | ssion) |
| | a. COUNTY W | Lcomico | MARYLAND | a. STATE Mar | yland ' | b. COUNTY W1 | comico | |
| | b. CITY OR TOW | VN (if outside corporate limits, and give nearest town) | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If | | nits, write RURAL | and give nearest t | own) |
| | Sa Sa | alisbury | | Sal | isbury | | 2 ./ | |
| | d. NAME OF HO | SPITAL OR INSTITUTION (if not in h | ospital, give street address) | d. STREET ADDRESS | | | B. IS RESIDE | |
| | Pe | en.Gen.Hospital | | 110 | 7 Middley | eck Dr. | | D X |
| | 3. NAME OF DECEASED | First | Middle | Last | 4. DATE OF | Month | Day Year | |
| | (Type or print) | AGNES | LILLIAN K | ENNEDY | DEATH FF | EB. 25 | | |
| | 5. SEX | 6. COLOR OR RACE 7. MARRIED | NEVER MARRIED - | B. DATE OF BIRTH | 9. AGE (In | | 1 YEAR IF UNDER 24 | 4 HRS Min. |
| | Female | White WIDOWED | DIVORCED | Mar. 28/190 | 01 64 | yrs. 10 | 27 | INTERIOR |
| | 10a. USUAL OCCUPAT | TION (Give kind of work done 10b. K | IND OF BUSINESS OR NDUSTRY | 11. BIRTHPLACE (Co | unty & State, or foreign | | TIZEN OF WHAT | |
| | Clark - | Department sto | | Crisfield | d, Marulan | | | |
| | 13. FATHER'S NAW | IE . | | 14. MOTHER'S MAID | | | | |
| | William | D.Nelson | | AZXXXX AR | na Belle | Laird | | |
| | | EYER IN U.S. ARMED FORCES? 16. | SOCIAL SECURITY NO. 17 | INFORMANT | Vanna 2 ml | Address | 12300 | |
| ĺ | No | | 14-28-8010 Mi | Warren R | verificant | nuspana |)1107 | 72 |
| | 18. CAUSE OF | DEATH [Enter only one cause per l | ine for (a), (b), and (c).] | durence 1 | | the Japanista | INTERVAL BETW | EEN |
| | PART I. DI | EATH WAS CAUSED BY: | 100 run Th | 100 lose 5 | asnat | Till. | ONSET AND DE | |
| | 4 70 | | | | 121 | 7-02 | | - |
| | Conditions, If | DOL 10 | LONG CUH | a melen | rio | | 2 yea | |
| ı | gave rise to | Immediate (| 0-10 | 0-01-00 | | | 0 | |
| | cause (a), s underlying caus | raring rate [| | | | | | |
| | | SIGNIFICANT CONDITIONS CONTRIBI | JTING TO DEATH BUT NOT RELA | TED TO THE TERMINAL D | ISEASE CONDITION GI | VEN IN PART 1(a) | 19. WAS AUTO | |
| | § 1) cen | 11. | when 2) | y. T. hemor | 4 | Esto | PERFORME YES NO | D? X |
| | 20a. ACCIDENT | MAS UNDERLYING D 20h | DESCRIBE HOW INJURY OCCU | | | | | LOI |
| i | PART II. OTHER S DOM: 20a. ACCIDENT OR CONTRIBUT (IF EITHER, NO | ING CAUSE OF DEATH TIFY MEDICAL EXAMINER) | | | | | | |
| | | 147/44 | NJURY OCCURRED 20s. PLAC | CE OF INJURY (Home, fai | rm. 20f. (City or to | own) (Cour | ntv) (Sta | te) |
| | E Hour &. | m. While | Not While factor | ry, street, office bldg., et | c.) | , | | |
| i | | | | Or la | 60 in Fel | 6 25 10 6 | / | 11 |
| | | fy that (1) (this hospital) attend | | App. | | · | (e, that (I) (we) ne date stated at | -tast |
| | 22a, SIGNATU | | 25 1966, and that | death occurred at | M, from the C | auses and on th | ie date stated at Ate signed | HOVE. |
| | 1 | 1 1 1 1 1 1 | Kan M.D | | MED. STAF | g . | -1/. | 2 |
| | 22c. PHYSICIA | AN'S | M.D | PHYS. X D | IRECTOR L PHYS | . Ul rep | 16/19 | 105 |
| 1 | NAME C | P. Robert T.Adk | ins | | l Marylan | đ | | |
| | 23a. BURIAL CREM | MATION, 23b. DATE THEREOF | 23c. NAME OF CEMETERY | | 23d. LOCATION (| | inty) (State | a) |
| | REMOYAL (Spi | Teb.28/1966 | | | | | Pa. | |
| | 24. FUNERAL DIRE | | ADDRESS | 25a, REC | D BY REGISTRAR 2 | | S SIGNATURE | |
| | HOLLOWAY | & COMPANY SA | LISBURY MARY | | 28 1966 | Ochanda | Α | |
| | | | | DAIL | 1000 | // | VA | |

VR A15 (4) 20M 1/65

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. 24 hours after death TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Page 4 may be retained by the hospital or attending physician.

> VR A15 (4) 15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

| | DIVISION OF STATISTICAL RESEARCH AND RECORD | DS, 301 W. PRESTON STREET, BALTIMORE 1, N | ARYLAND |
|---------------|--|--|---|
| | 33011 CERTIFICATION | TE OF DEATH | 998 |
| | PLACE DF DEATH | 1 2. USUAL RESIDENCE (Where deceased lived, If institution; R | esidence before admission) |
| X | 6. COUNTY MARYLAND | 3 STATE Y L (LAC) b. COUNTY | omico |
| _ | b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1) | | |
| (| write RURAL and give nearest town) 18days. | SALICRURY | , |
| | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street addres | s) d. STREET ADORESS | e. IS RESIDENCE |
| 1 | | 309 N. DIVICION | ON A FARM? |
| - | PANNSULA (DENERAL MOSPILA) NAME DF FIRST MIDDLE | Last 4. DATE Month | Day Year |
| 3. | DECEASED | OF - | 11 /1 |
| 5. | (Type or print) ///c///C SEX 6. COLOR OR RACE 7. MARRIEO NEVER MARRIEO | 1 8 DATE OF RIPTH 19 ACE (In years LIFTINGER | 1 1000 |
| 5 | I I I I I I I I I I I I I I I I I I I | 1 10 1895 (ast birthday) Months | Oays Hours Min. |
| 10a | USUAL OCCUPATION (Give kind of work done) 10b, KIND OF BUSINESS OR | 11. BIRTHPLACE (County & State, or foreign country) 12. C | TIZEN OF WHAT |
| dur | ng most of working life, even if retired) INOUSTRY | 05/11/0 115 60 | DUNTRY? |
| 13. | FATHER'S NAME | 14. MOTHER'S MAIOEN NAME | SA- |
| 1 | ELMER E. LECATES | LAURA RUARK. | |
| 15. | | - INFORMANT Address | 7 1 |
| (Ye | , no, or unknown) (If yes give war or dates of service) 214-10-6006 | Itta Henry - Delm | a heif |
| | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).1 | in hours | I INTERVAL BETWEEN |
| 1 1 | PART I. GEATH WAS CAUSED BY: M 1 1 | N 1 30 | ONSET AND OEATH |
| | IMMEDIATE CAUSE (a) PHOCORDIO - | wart rou | |
| \perp | Conditions to which I DUE TO (1. Les Co (-) | I Level Disco | |
| | gave rise to immediate (b) Urtriosclerct | ES DEVA DESSOR | |
| | cause (a), stating the OUE TO | | |
| 18 | underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RI | LATEO TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | 119. WAS AUTOPSY |
| E I | | 11 10011 | PERFORMED? |
| 기윤기 | | CURIEO. (Enter nature of injury in Part I or Part II of Item 18 | |
| CERTIFICATION | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | Continue (miles) in miles of miles of the continue of the cont | • |
| | | LACE OF INJURY (Home, farm, 20f. (City or town) (Cot | inty) (State) |
| EDICAL. | Hour a.m. While - Not While - fa | ctory, street, office bldg., etc.) | , |
| Z | p.m. 19 at work at work | Jan 27 1966 to Feb 17.196 | Ahat (I) (un) look |
| | 21. I certify that (I) (this hospite) attended the deceased from saw the deceased alive on FC 13 1966, and the | Tou 27, 1966 to Feb 14, 1969 hat death occurred at 12 MM, from the causes and on t | |
| 1 1 | saw the deceased alive on Feb 13 1966, and to | 1 22h. D | ATE SIGNEO |
| ш | | M.D. ATTENOING MEO. OIRECTOR PHYS. 2 | 14/66 |
| | 22c, PHYSICIAN'S | 220 AOORESS ON M. C. | |
| Н | NAME (Type) | Time Bluff Road, Solis | shury, Md |
| 23a | | ERY OR GREMATORY - 23d. LOCATION (City, town or co | unty) (State) |
| 1 | REMOVAL (Specify) 2-16-66 | thene Wilman | duf |
| 24. | FUNERAL DIRECTOR A ADDRESS | 25a. REC'D BY REGISTRAR 25b. REGISTRAR | |
| 6 | Karley H Hazul Vell 18 | - Les offEB 16 1966 flavle | Judge |



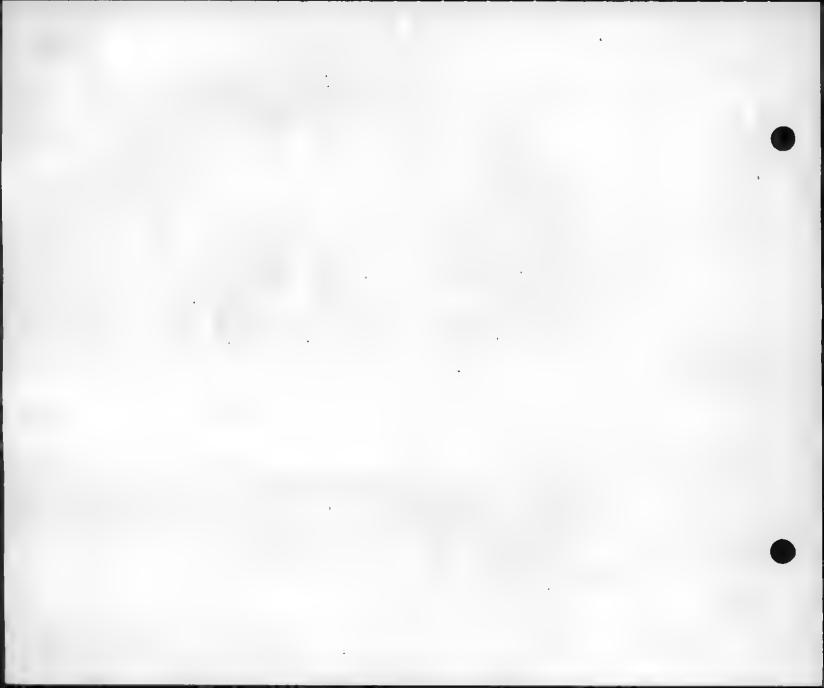
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH and 2 death: funeral 24 hours after death PLACE OF DEATH HSVAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY completely filled in by the f ve carbon papers. Pages 1 event, within 72 hours after COMICO MARYLAND CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS within NAME OF Middle DATE Last 4. DECEASED (Type or print) DEATH 0 an end con 5. SEX 6. COLOR DATE OF BIRTH 8. 7. MARRIED NEVER MARRIED lease remov and in any EMALE WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY during most of working life, even if retired) physiki death certificate ᆸ or removal. MOTHER'S MAJOEN NAME Then TO FUNERAL DIRECTOR: After this certificate has been signed by the attending director, page 3 should be detached for use as the burial-transit permit. They should be filed with the State Dept. of Health prior to burial, cremation, or remov 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no. or unkown) (If yes over war or dates of service) CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] 10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Page 4 may be retained by the hospital or attending physician. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate DUE TO cause (a). stating underlying cause last. (c) PART H. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATI 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hour a.m. Not While et work While OR ATTENDING at work p.m. 21. I certify that (I) (this hospital) attended the deceased from 19 saw the deceased alive on and that death occurred at 22a, SIGNATURE ATTENDING PHYS. DIRECTOR M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) BURIAL, CREMATION, 23b. DATE THEREOF 23d. 23a.

b. COUNTY TOWN (If outside corporate limits, write RURAL and give neerest town) B. IS RESIDENCE ON A FARM? NO P YES Month Day BRU 1966 AGE (In years | IF UNDER 1 YEAR last birthday) Months Hours (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? Address INTERVAL BETWEEN ONEZT AND DEATH WAS AUTOPSY PERFORMED? YES TO NO DESCRIBE HOW INJURY OCCURRED, (Enter nature of Injury in Pert 1 or Pert 11 of Item 18.) 20f. (City or town) (County) (State) that (I) (we) last M, from the causes and on the date stated above. 22b. DATE SIGNED STAFF PHYS. LOCATION (City, town or county) (Stete) NAME OF CEMETERY OR CREMATORY ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

VR A15 (4) 15M 4-64

REMOVAL (Specify)

UMERAL DIRECTOR



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| FOR STATE | | | | | | |
|--|---|---|--|--|--|--|
| HEALTH DEN | 1 | 1 | | | | |
| delay is and 3 to M3. Page ritment of ier death. | | ŀ | | | | |

Item 18. Give Pages 24 haurs after death.

in pencil in

This certificate shauld be executed within

TAL EXAMINER:

the funeral director.

alang with

Office

the Chief Medical Examiner's

cate, writing the ward be farwarded to the Ch

12 m K

ō after death. State Department haurs he within pub remayal. 0 crematian, burial, a 2 prior 3 shauld its designated agent,

PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission o. COUNTY Wicomico Maryland MARY, AND b CITY OR TOWN (If autside carporate mits, CLENGTH OF STAY IN 1b c CITY OR TOWN (f autside carparate limits, write RURAL and give nearest town) write RURAL and give nearest town) Stockton Salisburv d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS Peninsula General Hospital Route 2, Box 95 3 NAME OF First. M.dd e DATE Manth DECEASED OF CHARLES THOMAS MARSHALL (Type or print) DEATH 5 SEX 8 DATE OF BURTH 9. AGE (n years 6 COLOR OR RACE 7 MARRIED NEVER MARRIED lost hirthdoy) 2-9-35 WIDOWED DIVORCED 10b KIND OF BUSINESS OR 11 BiRTHPLACE (Stote or foreign country) 10g SUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INDUSTRY Factory Laberer Mary and
14 MOTHER'S MATDEN NAME 13 FATHER S NAME Lucinda Cerbin Cellins Thomas 16 SOCIAL SECURITY NO 17 INFORMANT IS WAS DECEASED EVER IN J. S. ARMED FORCES? Address (Yes, no, ar unknown) (If yes give war ar dates of service) 218 34 9515 Geraldine Marshall 18 CAUSE OF DEATH (Enter on y one couse per line for (o), (b) and (c) PART I. DEATH WAS CAUSED BY Asphyxia with pulmonary edema MMED ATE CAUSE (o) DUE TO Contused larvnx with hemorrhage and edema Conditions, if only, which gove rise to immediate couse (a) DUE TO stating the underlying couse last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART I(a) 200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Part I or Port II of item 18.) PRIMARY or CONTRIBUTING Passenger in car involved in accident. CAUSE OF DEATH 20e P.ACE OF INJURY (Home form 20f (City or town) 20c TIME OF INJRY Manth, Day, Year factory street office bldg , etc.) ĬX. Highway Oak Hall of work at work 21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection X, death resulted from Acc dent X Natural causes Suicide [Hamicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER SIGNATURE Health or DEPUTY MEDICAL EXAMINER L. Royer, EXAMINER'S Address (Street, city, town, or county) Camdon Avd Salisbury Md.

23b DATE THEREOF 23c NAME OF CEMETERY OF CREMATORY BUR AL CREMATION 23d LOCATION (City or Town) 2/25/16 Mt. Hepe

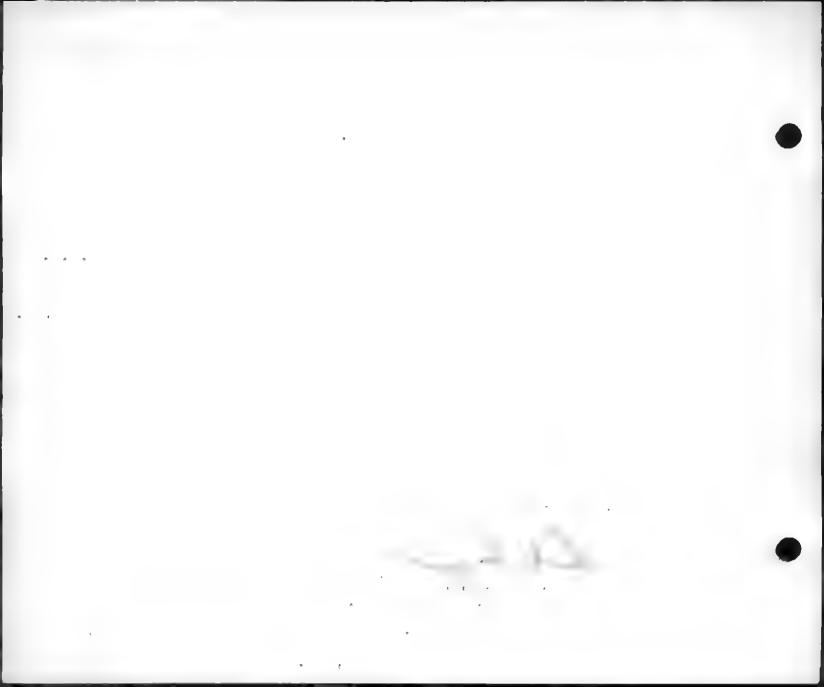
Worcester e IS RES DENCE ON A FARM? YES NO TO Year 2-20-66 19 IF UNDER A YEAR E UNDER 24 HRS Dovs Hours 12 CITIZEN OF WHAT COUNTRY? Steckten, Md. INTERVAL BETWEEN ONSET AND DEATH 22 hours WAS AUTOPSY PERFORMED? YES TO NO Va. Inquiry and in my apinian 22. DATE SIGNED 2-211-66 (State) Steckten

25b REGISTRAR'S SIGNATURE

250 REC'D BY REGISTRAR

VR A15ME (5) 6M 1/66

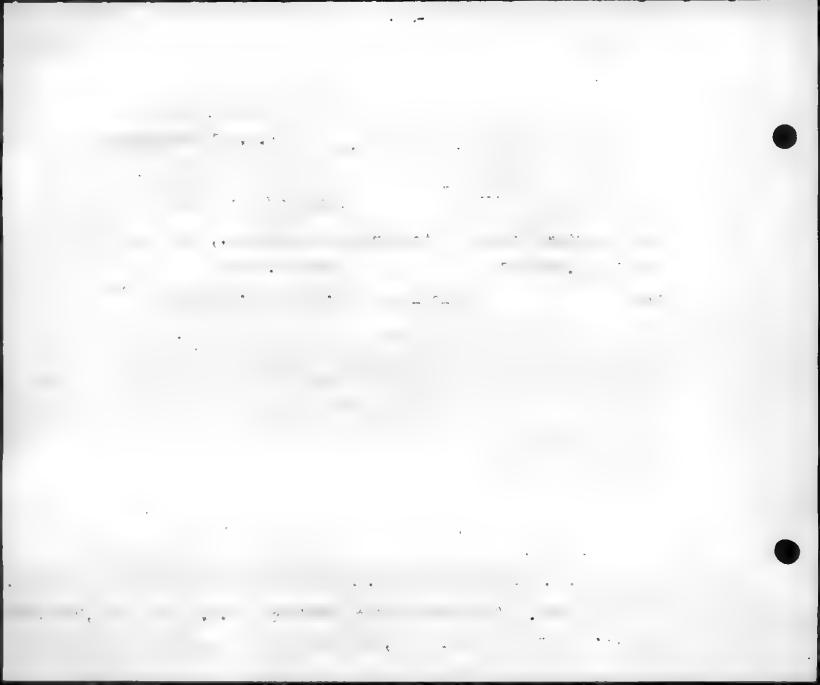
24. FUNERAL DIRECTOR



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH and 2 death. after duath. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY b. COUNTY by the figeral pages 1 urs after... Wicomico MARYLAND Wi comi co b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury .⊑ days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) filled d. STREET ADDRESS a. IS RESIDENCE ON A FARM? R.D.# Deer's Head State Hospital. Salisbury. Md. NO X etely within completely control 3. NAME OF DATE Month Last DECEASED OF (Type or print) DEATH Clifford Penn Marshall February executed DATE OF BIRTH ACE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. q) 7. MARRIED TENEVER MARRIED last birthday) Months WIDOWED DIVORCED [Male White 10a. USUAL OCCUPATION (Cive kind of work done | 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT (C) during most of working life, even if retired) COUNTRY? Shop Service Manager Auto Garage SA Wicomico Co. Marvland ed by the attending pays transit permit. Then plo cremation, or removal, 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME William E. Marshall Rona B.Jones 16. SOCIAL SECURITY NO. Mrs.Esther A. Marshall (Wife) (Yes, no, or unkown) (If yes give war or dates of service) 28 above 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] signed by th urial-transit INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Bronchogenic carcinoma of left lung with attending physician, IMMEDIATE CAUSE (a) metastasis to neck; and pulmonary atelectasis Months DHE TO fleen sig the burish Arteriosclerottc cardiovascular disease with (b) gave rise to immediate coronary insufficiency Years DUE TO cause (a), stating the prior underlying cause last. 53 CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART 1(a) WAS AUTOPSY for use Health p PERFORMED? certificate Ы NO T the hospital 20a. ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part | or Part || of Item 18.) detached for the Dept. of H this TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) After to d be de s State factory, street, office bldg., etc.) Hour a.m. pm, DIRECTOR: Af age 3 should be iled with the S retained 21. I certify that (I) this hospital) attended the deceased from December 8, 1966, to February 9, 1966, that (I) (we) last saw the deceased alive on Telaniary 9 1966, and that death occurred aBJ15AM, from the causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED director, page should be filed v 2/9/66 M.D. DIRECTOR PHYS. 22c PHYSICIAN'S FUNERAL ADDRESS Gutierrez-Carrido, M.D. Deer's Head State Hospital, Salisbury, Md. BURIAL, CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) Shad Point Cemetery Burial .D Salisbury Maryland 25a. REC'D BY REGISTRAR FUNERAL DIRECTOR SALISBURY, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH

VR A15 (4)



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correletely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please rehave carbon papers. Pages 1 and a should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after deadn. TO HOSPITAL OR ATTENDING PHYSICIAN: The lam requires that the death certificath by executed within 24 hours after leath.

Page 4 may be retained by the hospital or attending physician.

> VR A15 (4) 15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| 1. PLACE OF DEATH a. COUNTY | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) |
|---|---|
| | a. STATE b. COUNTY |
| b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| WIITE RUKAL and give nearest town) | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | d. STREET ADDRESS a. IS RESIDENCE |
| | ON A FARM? |
| Reninsula Deneral | 1 1) 0 x 2/2, (64/4 2 YES ND |
| 3. NAME OF FIRST Middle | Last 4. DATE Month Day Year |
| (Type or print) /atherine Ma | etthews DEATH & Dillary 26 1966 |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min. Hours Min. |
| temate negroe WIDOWED DIVORCED | Lec. 10, 1921 38 yrs. Months 1835 Hours |
| 10a. USUAL OCCUPATION (Give) find of workdone 10b. KIND OF BUSINESS OR during most of working life, even if retired) | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY2. |
| Laborer Factory | Md VISA. |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME, |
| I Edward Waters | Katie Wilson |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. | INFORMANT |
| (Yes, no or onkown) (If yes give war or dates of service) | oland Miller Page on la City Md |
| 1 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c), 1 | rlando Illa Hhews rocomoke City, l'a. |
| BART 1 DEATH WAS CAUSED BY | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Caramona | Sum: |
| 1008 DUE TO a multiply | a Milter time. |
| Conditions, If any, which gave rise to immediate (b) | |
| cause (a), stating the DUE TO | |
| underlying cause last. (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOTRE | ATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? |
| Figure | YES NO |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT REL 20a. ACCIDENT WAS UNDERLYING TO CONTRIBUTING TO CAUSE OF DEATH OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | URRED. (Enter nature of injury in Part I or Part II of Item 18.) |
| | |
| | ACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) ory, street; office bidg., etc.) |
| Hour a.m. p.m. 19 While Not While ract | ory, street office page, etc.) |
| 21. I certify that (I) (this hospital) attended the deceased from_ | //5/ 1966, to 2/26/, 1966, that (I) (we) last |
| | at death occurred at Soem, from the causes and on the date stated above. |
| 22a. SIGNATURE | 22b. DATE SIGNED |
| M. M. | D. PHYS. DIRECTOR PHYS. |
| 22c. PHYSICIAN'S | 22d. ADDRES\$ |
| NAME (Type) | |
| 232 BURIAL, CREMATION, 23b. DATE THEREOF 23c, NAME OF CEMETER | Y OR CREMATORY 230 LOCATION (City, town or county) (State) |
| REMOVAL (Specify) 3-3-66 Maio Will | · Com Pagamata City, Md |
| 24 EUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |
| Mary Chill | och Va MAR 3 1979 Minde Cutet |
| January Responsible Char | Child Dake AR O 15001 |



MARYLAND STATE DEPARTMENT OF HEALTH **DIVISION OF STATISTICAL RESEARCH** 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

| | 03016 | Alalaman Itulamani | CERTIFICAT | E OF DEATH | | 03003 |
|---------|---|--|-------------------------------------|---|--|--|
| | PLACE OF DEATH | | | | CE (Whare deceased lived, If ins | stitution: Residence before admission) |
| - | b. CITY OR TOWN (f outs do coverita RURAL and give neers | orporeta limits, | MARYLAND c. LENGTH OF STAY IN 16 | Mary la | | Wicomico V |
| _s | alisbury | Si | nce 7/6/65 | Salish | oury | Property. |
| Pi | d. Name of Hospital or ins | | a, g vo sîresî eddress) | d STREET ADDRESS | | os RESIDENCE ON A FARM? |
| 3. | NAME OF DECEASED (Type or print) | First Phillip | McCready | Spring last | Hill Road 4. DATE Month OF DEATH Foh. | Day Year 19 1966 |
| 10a | | R OR RACE 7. MARRIED WIDOWED kind of work 10b, K NO | NEVER MARRIED DIVORCED | oct. 13, 187 | | UNDER 1 YEAR I IF UNDER 24 HRS. |
| 13. | Carpenter FATHER'S NAME | - | | Dagsboro, | | USA |
| (Ye | was deceased ever in J.s. s, no, or unkown) ((fyesgivawe NO 18. CAUSE OF DEATH [En PART 1. DEATH WAS CA | erordates of serv.ce, [22] that only one ceuse per line (USED BY: | L-09-8818 A | Records of | Pine Bluff St | INTERVAL BETWEEN ONSET AND DEATH |
| | | E CAUSE (a) | Pulmonal | ry Tuberculo | 815 | Unknown |
| | Conditions, if any, which gove rise to immediate cause (a), stating the underlying cause last. | DUE TO | | | | - |
| CATION | | ANT CONDITIONS CONTR | RIBUTING TO DEATH BUT NO | OT RELATED TO THE TERMI | NAL DISEASE CONDITION GIVEN | IN PART 1(e) 19. WAS AUTOPSY PERFORMED? |
| CERTIF | 2Da, ACCIDENT WAS UNDER OR CONTRIBUTING CAUSE (IF EITHER, NOTIFY MEDICAL | OF DEATH | BE HOW INJURY OCCURE | D. (Enter neture of in ury in | Pert I or Pert II of Jem 18.) | |
| MEDICAL | 20c. TIME OF INJURY Mor Hour a.m. p.m. | nth, Dey, Yeer 20d. IN. While 19 at work [| | ACE OF INJURY (Home, fern trory, street, off ce bldg., etc | | (County) (Stele) |
| | | | | - | | , 19 . 6.6 that (1) (we) last |
| | saw the deceased alive 228 SIGNATURE | on .Feb28. | 19 6.6 , and tha | | 30%, from the causes as | nd on the date stated above. 22b, DATE SIGNED |
| | 22c PHYSIC AN'S NAME (Type) | Rileti | nep 1 | | RECTOR PHYS. | Feb. 28, 1966 |

238. BURIAL, CREMATION, 23b. DATE THEREOF BUP181 3-3-66 24 FUNERAL DIRECTOR'S SIGNATURE

23c. NAME OF CEMETERY OR CREMATORY St Stephens

23d. LOCATION (City, fown or county)
Delmar, Del.

Salisbury, Maryland

25a, REC'D BY REGISTRAR | 25b, REGISTRAR'S SIGNATURE 1966

death, Page 4 (1) be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending of director, page 3 should be detached for use as the burial-transit permit. Then please be filed with the State Dept. of Health prior to burial, cremation, or removal, and in TO HOSPITA 15M 9/60

Pysicen and completely filled in by the funeral process, a carbon papers. Pages I and 2 should my yeart, within 72 hours after death.

hin 24 hours after

The law requires that the death certificate be executed,

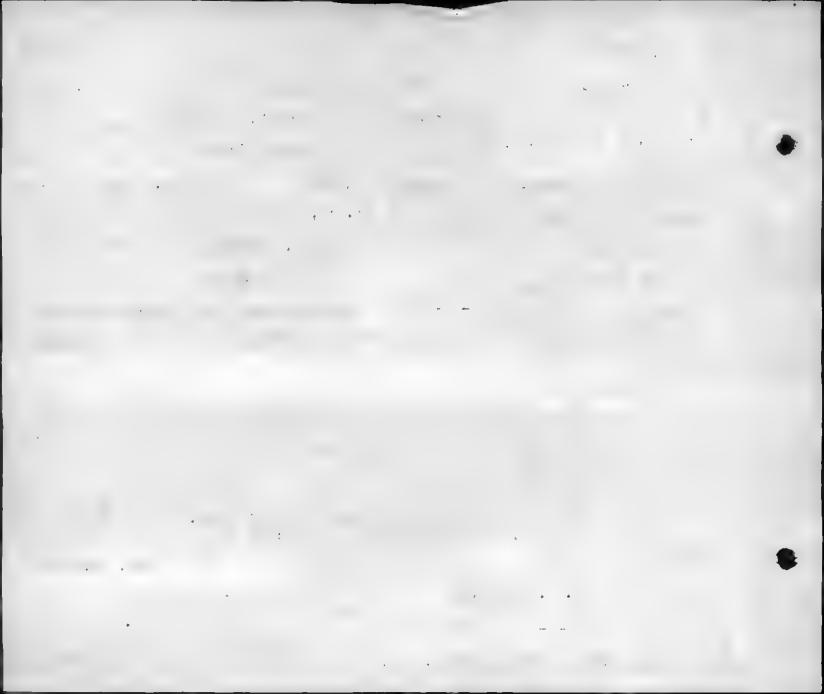
ATTENDING PHYSICIAN:

Marvil Funeral Home

ADDRESS Delmar, Del.

E. P. Ritchings

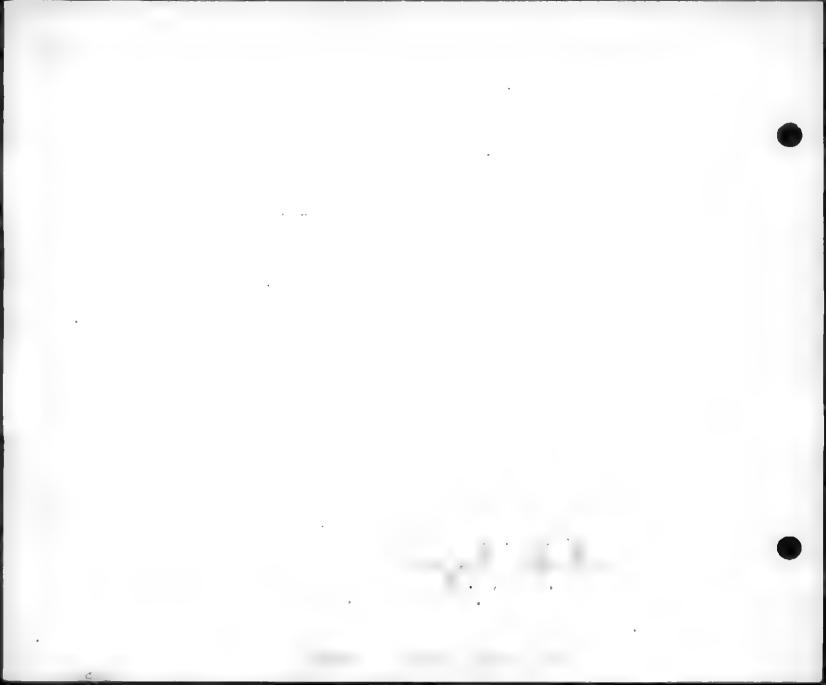
director, page 3 should be detached for use be filed with the State Dept. of Health prior



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STAT HEALTH DERT PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lead, flinst tution Residence before admission) a COUNTY Maryland b COUNTY Wicamico o STATE 2, and 3 ta PM3. Page Wicomico Department b CITY OR TOWN (it outside corporate mits LENGTH OF STAY IN 16 t CITY OR TOWN (f outside carporate limits, write RURAL and give nearest tawn) wr to RJRAL and give nearest town) Quantico d NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS e IS RESIDENCE ON A FARM? with form Peninsula General Hospital YES NO pending" in pencil in Item 18. Give Pages of Medical Examiner's Office along with for e State .F.D. This certificate shalld be executed within 24 hours after death 3 NAME OF First Middie Last 4 DATE Month 2-28-66 DECEASED OF Dominick Eugene Morris (Type or print) DEATH Office alang 9 AGE (n years SEX 6 COLOR OR RACE F. INDER 1 YEAR F UNDER 24 HRS 7 MARRIED NEVER MARRIED B. DATE OF BIRTH last birthday) 2-11-66 Opti Hours AA WIDOWED DIVORCED and 10a USUAL OCCUPATION (Give kind of work done 1Db KIND OF BUSINESS OR 11 BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) **INDUSTRY** COUNTRY? VПР pages in any Non Maryland

14. MOTHER'S MAIDEN NAME U.S.A 13. FATHER'S NAME Edna Morris Juantico Md. R.C. Shivers IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no. or unknown) ((If yes give war or dates of service) remayal no Edna Morris .uantico Md R.F. INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) PART | DEATH WAS CAUSED BY Officiant BEATH Interstitial pneumonitis ь IMMEDIATE CAUSE (a) 9 s a bunal-tra cremation, (the certificate, writing the ward DUE TO farwarded to the Conditions, if any, which gave (b) rise to immediate cause (a), DUE TO stoting the underlying cause used as burial, c PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS ALTOPS ERFORMED? NO pe designated agent, prior ta 2Da EXTERNAL CAUSE WAS 20b DESCR BE HOW MURY OCCURRED (Enter nature of injury in Part 1 or Part 11 of item 18) 3 shauld PRIMARY CONTRIBUTING CO should CAL EXAMINER: CAUSE OF DEATH 20c TIME OF INJURY Month, Day, Year 2Dd NJURY OCCURRED 2De PLACE OF INJURY (Home, form (City or town) (County) (State) Hour a.m. While factory, street, office bldg., etc.) FUNERAL DIRECTOR: Page Page . at work of work Inspection A 21. I certify that I taak charge of the remains described above, held an Autopsy. [A Industry Pa and in my opinion the funeral directar. deoth resulted from Natural causes Accident . Suicide Hamicide Undetermined monner CHIEF MEDICAL EXAMINER **ACTUAL** 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE MEPUTY 5 may be 10 FUNERAL Health or 11 Royer. M.D. DEPUTY MEDICAL EXAMINER X 3-1-66 Ear 1 EXAMINER'S NAME (Type) 1:09 Camden Ave. Address (Street, city, town, or county) Balisbury, Md. 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL CREMATION. 23b DATE THEREOF 23d LOCATION (City or Town) (County) burial (Specify) 966 Rockawalking 24 FUNERAL DIRECTOR VR ATSME (5) 6M 1/66



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicial and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. hours after death. executed within O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be Page 4 may be retained by the hospital or attending physician. TO HOSPITAL

MEDICAL

| DIVISION OF STATISTICAL RESEA | | , 301 W. PRESTO | N STREET, BA | LTIMORE 1, | 4.1 | 7 4 5 10 |
|---|-------------------------------|------------------------------|-------------------|------------------------------------|---------------------------------|------------------------|
| 03018 | CERTIFICATI | E OF DEATH | | | 1/6 | 004 |
| 1. PLACE OF DEATH a. COUNTY Wicomito | MARYLANO | a. STATE Maryl | | b. COUNTY | Residence before Comic | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (If Delmar | outside corporate | ilmits, write RUR | AL end give n | earest town |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in ho 205 Elizabeth Street | ospital, give street address) | d. STREET ADDRESS 205 El1 | zabeth | | e. IS Of YES | RESIDENCI N A FARM? |
| 3. NAME OF First DECEASED (Type or print) WILLIAN HE | Middle NRY EDWIN | NOCK SR. | 4. DATE | Month Feb | Day 8 | Year 19 66 |
| 5. SEX 6. COLOR OR RACE 7. MARRIED White WIOOWED | | 2-6-1904 | O ACE | in years IFUND birthdey) Months | ER 1 YEAR IFU | |
| during most of working life, even if retired) IN | ND OF BUSINESS OR IDUSTRY | Crisfie | | | CITIZEN OF V COUNTRY? JSA | VHAT |
| 13. FATHER'S NAME | | 14. MOTHER'S MAID | | | | |
| William C. Nock | | Lena P | arks | | | |
| (Yes, no. or Unkown) (If yes give war or dates of service) | 16-05-3763 | Sue Nock | , Delmar | Address Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | fe for (a), (b), and (c).] | from | agani | 2 | ONSET A | L BETWEEN |
| Conditions, If any, which gave rise to immediate (b) | | / | | | | |
| cause (a), stating the DUE TO | | | | | | |

(c) CERTIFICATION PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED, (Enter nature of Injury In Part 1 or Part 11 of Item 18.)

20d. INJURY OCCURREO TIME OF INJURY Month, Oay, Year Hour a.m. While at work Not While at work p,m. 19

deceased

21. I certify that (I) (this hospital) attended the and that death occurred at saw the deceased alive or M, from the causes and on the date stated above DATE SIGNED 22a. SIGNAJURE 22b. MED. DIRECTOR 2-9-66 ATTENDING PHYS. STAFF PHYS.

NAME OF CEMETERY OR CREMATORY

20e. PLACE OF INJURY (Home, farm,

22d.

factory, street, office bldg., etc.)

22c. PHYSICIAN'S NAME (Type) L.V. Sohler ADDRESS Delmar. Md

LOCATION (City, town or county)

(City or town)

(State) Delmar

(County)

WAS AUTOPSY PERFORMED? NO F

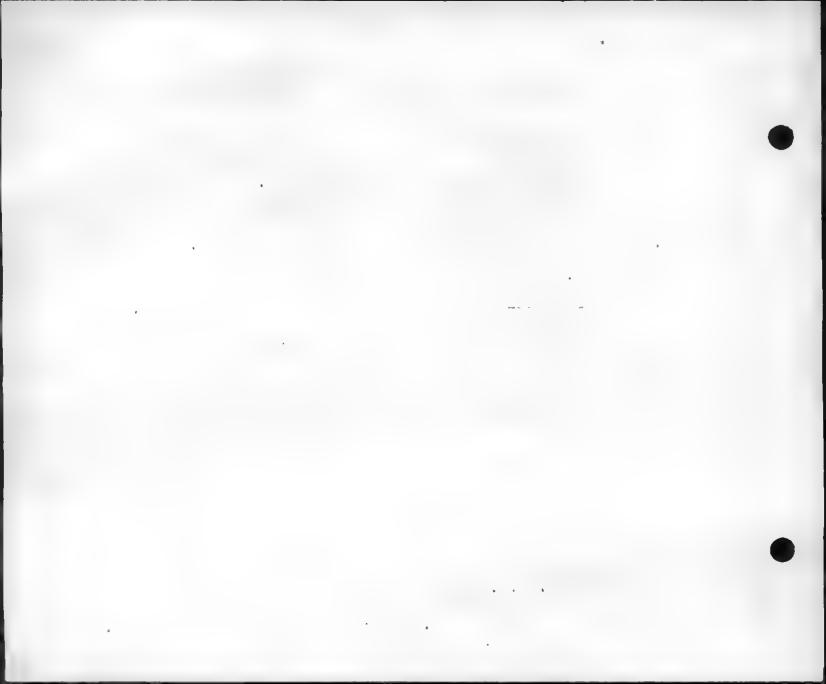
(State)

a. BURIAL, CREMATION, REMOVAL (Specify)
Burial ADDRESS ADDRESS St. 2-12-66 FUNERAL DIRECTOR

DATE THEREO!

25a. REC'D BY REGISTRAR

Del. 25b.



VR A15 (4) 15M 4-64

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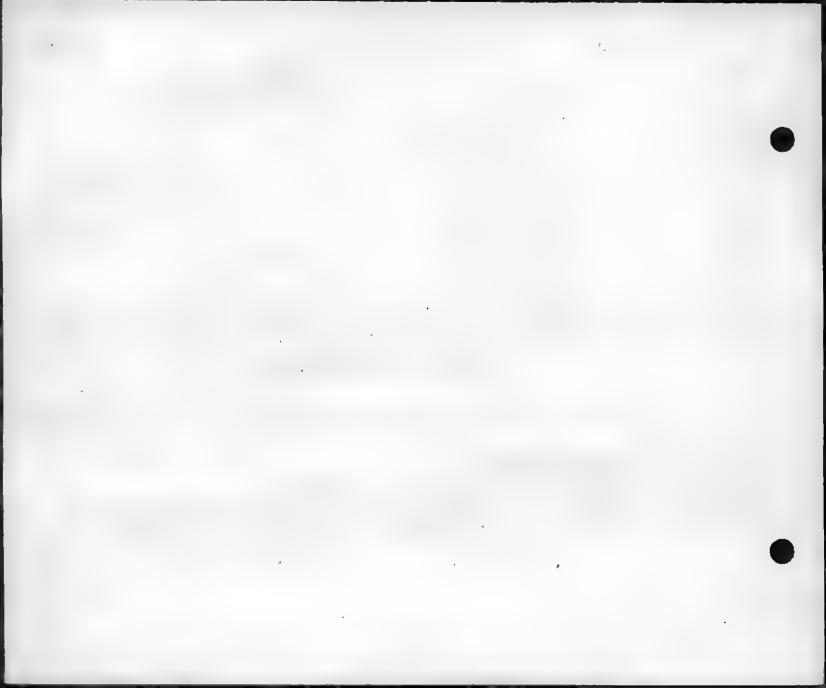
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BA

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| 1. | PLACE OF DEATH | H | | | 2. USUAL R | RESIDENC | E (Where dece | ased lived, If Inst | itution: Resid | ence before a | admfssion) |
| | | | J1 | | | Ε, | / | b. COUNT | 1.1010 | | ń |
| | W/C | m ico | 7 | | | MAR | PYLANI |) | WURC | E5/E/ | < |
| | Write RURAL | and give nearest to | ate limits, | C. LENGTH OF STAY IN | b c. GITY OR | TOWN (IT | putside corp | orate limits, writ | e KUKAL and | give neare | St town) |
| | SALI | CAURY | , | 5 DAUS | 1 7 | 200 | 11- 7 | CAMAVE | dila. | Ŋ | |
| | d. NAME OF HO | SPITAL OR INSTITUTI | ON (If not in I | hospital, give street addre | d. STREET A | DDRESS | 16 10 | UMUNE | | e. IS RE | SIDENCE |
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| | | UL/7 WEI | UEKAL | HOSPITH | <u> </u> | K.F. | D. 3 | | | YES X | ND |
| 3. | | F | Irst | Middle | Last | | 4. DATE | Month | 1 | ay Ye | ear |
| | (Type or print) | HARAID | 1 | OFF MAN | PAVM | /- | | FERRUI | ARV 3 | 2 19 | 6/2 |
| 5. | | | 7 MARDICE | | | IRTH | . 9. | ACE (In years II | | | - 4 |
| \ v | 20010 | 1.111 | | | 0.70 | 1000 | 7 7 | last birthday) | | | |
| 11 | 11475 | 1 1 / / ' | | | OC1. 8, | 188 | 3 2 | of yrs. | | | |
| 10a dur | I. USUAL OCCUPAT | ION (Give kind of wor) | kdone 10b, | | 11. BIRTHP | LACE (Co | ounty & State, | or foreign country) | | | ,T |
| | | | L. | - 4 | WORC | ESTE | & COUN | 141 | | | |
| 13. | FATHER'S NAM | E | 1 [] | TRIFLINGO | 14. MOTHE | CS MAID | FN NAME | | | 3 , , , , | |
| | | 7. | | | 141 | l . | | | | | |
| | JOHN. | MAYNE | | | HES | TER | MAY | NE | | | |
| 15. | . WAS DECEASED! | EVER IN U.S. ARMED F | ORCES? 16 | SOCIAL SECURITY NO. 1 | 7. INFORMANT | | , | Address | R.F. | 7. 3 | |
| (10 | | (11) es grie mai di dates | VI aci lice) | AIDITE | Pirihapa | TON | IFS N | MOMOKE | N.6. | ba) | |
| - | | DEATH CEnter only o | 20 001100 201 | | TOPPIND | 4014 | 19 16 | COMMONE | | TroVAL DI | ETWEEN |
| | | | | Title for (a), (b), and (c). | - | | | | | | |
| Н | PART I. DE | IMMEDIATE CAUSI | (a) | Freumon | die | | | | | 8-100 | un |
| | 11 7 0 | A DUE | TO | | | | | | | | |
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| H | | rariis file [| E 10 | | | | | | | | |
| _ | | | (c) | | | | | | | | |
| | PART II. OTHERS | SIGNIFICANT CONDIT | IONS CONTRIB | BUTING TO DEATH BUT NOT R | ELATED TO THE TE | RMINAL D | ISEASECOND | ITION GIVEN IN P | ART 1(a) | 9. WAS A | UTOPSY RMED? |
| 5 | 1) The. | L. 11.1. | tion of | 184 DA. | Jun Da | Jan . | Klean | + Mure | _ | | NO X |
| | 202. ACCIDENT | WAS LINDERLYING | 1 20b. | DESCRIBE HOW INJURY OF | CURRED. (Enter | nature of | Injury in Par | t I or Part II of | Item 18J | | |
| 6 | OR CONTRIBUTI | NG CAUSE OF DE | ATH | | , | | ,, | | | | |
| | | | | | | | | | | | |
| [절 | | | | fo | LACE OF INJURY | (Home, fa | rm, 20f. (| lity or town) | (County) | | (State) |
| @ | | | While | BILLY TON TON TON | 0,013, 311 001, 01110 | a piaga vi | , | | | | |
| ≥ | | | | | / 01 | | 1/1 | 2 0 | - 10 // | Abot (II) | Count Inna |
| ΙI | | _ | pital) attend | ded the deceased from_ | 1-25 | , 15 | 30, to_ | d- d | _, 19_ <i>G26</i> ; | that (I) | we) last |
| | | | 2 - | 2 -19 46, and t | hat death occur | red at.d | P M, fro | m the causes a | | | d above. |
| | 22a. SIGNATUR | RE / | 0 | 0.11 | | | | 27274 | 22b. DATE | SIGNED | |
| | | Vm | m. h. C | March | | 178 | MED. DIRECTOR | | 2- | 2-1-6 | |
| | 22c. PHYSICIA | N'S | | /// | | | | 43 | 13 | | |
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| 120 | DUDIES COST | INTION LOCK | TUEDEOF | 1 CANTONO | TOW OR T | | 1.004 104 | ATION (ALL | | | thata. |
| 238 | | ecify) 23b. DATE | THEREOF | 23C. NAME OF CEMET | ERY UN-CHESING | NT A | 23d. LOC | ATION (City, to) | vn or county | 19 | state) |
| | BURIA. | L 12-6 | -1966 | REMSON | METHODI | 157 | WORCE | STER COU | NTY, M | ARYL. | AND |
| 24. | . FUNERAL DIRE | CTOR / | | ADDRESS | 2 | 5a. REC | D BY REGIS | | | GNATURE | |
| 17 | Shelist. | H. 44 75 | en h | COMOKE City | mil | MIR D | 3 10 | 66 (21 | ante. | so dos | |
| | MEDICAL CERTIFICATION 123 238 | a. COUNTY L. CITY OR TOW Write RURAL A. NAME OF HOR J. COUNTY d. NAME OF HOR J. COUNTY d. NAME OF HOR J. COUNTY J | a. COUNTY D. CITY OR TOWN (If outside corporwite RURAL and give nearest to SAL | a. COUNTY D. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) A 1 / S | ARYLAND D. CITY OR TOWN (if outside corporate limits, write Rural and give nearest town) J. AL S. OR S. STAY d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address of pecases) J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address of pecases) J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address of pecases) J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address of pecases) J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address of pecases) J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address of pecases) J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address of pecases) J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address of pecases) J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address of pecases) J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address of pecases) J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address of pecases) J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address of pecases | 1. PLACE OF DEATH 2. COUNTY 2. COUNTY 3. COUNTY 4. COUNTY 4. COUNTY 5. CITY OR TOWN (if outside corporate limits, with representation of the property of the p | 1. PLACE OF DEATH 2. COUNTY COMMISSION (IS OUTSIDE COXPORATE HIMITS, C. LENGTH OF STAY IN 1D D. CITY OR TOWN (IS OUTSIDE COXPORATE HIMITS, WITH STAY IN 1D D. CITY OR TOWN (IS OUTSIDE COXPORATE HIMITS, WITH STAY IN 1D D. C. CITY OR TOWN (IS OUTSIDE COXPORATE HIMITS, WITH STAY IN 1D D. C. CITY OR TOWN (IS OUTSIDE COXPORATE HIMITS, WITH STAY IN 1D D. C. CITY OR TOWN (IS OUTSIDE COXPORATE HIMITS, WITH STAY IN 1D D. C. CITY OR TOWN (IS OUTSIDE COXPORATE HIMITS, WITH STAY IN 1D D. C. CITY OR TOWN (IS OUTSIDE COXPORATE HIMITS, WITH STAY IN 1D D. C. C. CITY OR TOWN (IS OUTSIDE COXPORATE HIMITS, WITH STAY IN 1D D. C. C. CITY OR TOWN (IS OUTSIDE COXPORATE HIMITS, WITH STAY IN 1D D. C. C. CITY OR TOWN (IS OUTSIDE COXPORATE HIMITS, WITH STAY IN 1D D. C. | 1. PLACE OF DEATH 2. COUNTY 2. U. C. C. COUNTY 3. COUNTY 4. C. | 1. PLACE OF DEATH 5. COUNTY COUNTY COUNTY MARYLAND D. CITY OR TOWN (If outside corporate limits, with a stract address) C. LENGTH OF STAY IN 10 D. CITY OR TOWN (If pdtside corporate limits, with a stract address) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital) C. HAME OF HOSPITAL OR INSTITUTION (If not in hospital) C. HAME OF HOSPITAL OR INSTITUTION | 1. PLACE ON DEATH 2. USUAL RESIDENCE (Where decessed fixed, it institutions resides as STATE 3. STATE | 1. FLAGE OF DEATH 1. FLAGE OF DEATH 1. C. ON TO WHOTE QUESTION OF THE PROPERTY OF STAY IN 10. 2. USUAL RESIDENCE (Where decased lived, if institution: Recidence before is, STATE 1. S |



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND Udlug

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| leat mer | 1. | PLACE OF DEATH a. COUNTY | | | there deceased lived, If Institution: | Residence before admission) |
| 1 10 | | a. COUNTY | MARYLAND | a STATE | b. COUNTY | mc. rset |
| att att | / - | b. CITY OR TOWN (If outside corporate limits, c. LE | NGTH OF STAY IN 1b | | de corporate ilmits, write RURA | |
| in by S. Pag | | write RURAL and give nearest town) | LWEEKS. | 82 - 1 -1 | 102-0 | / |
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| E 2 2 | 5. | 057 | EVER MADRIED 1 8 | DATE OF BIRTH | V - V/ W 1~/ V/ | 17 19 66 R 1 YEAR IF UNDER 24 HRS. |
| and collemove | | WHOOWED N | DIVORCED 7 | UNE-24-188 | last birthday) Months | Days Hours Min. |
| n at | 10: | | BUSINESS OR | | & State, or foreign country) 12. (| CITIZEN OF WHAT |
| A 38 E | | ing most of working life, even if retired) ANDUST | mer | SOBBNE | | COUNTRYT |
| き (国語) | 13 | FATHER S NAME | 77 | 14. MOTHER'S MAIDEN N | IAME - | 0/ 3/1/ |
| g phys | 1.~ | HERBERT E PEAB | VAZ | GEORGIE | F. W161 | + T |
| nding properties of There | 3.6 | 71 3 | | INFORMANT | Address | NA STEA |
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| l leath the atte t permit ation, or | - | /XU 720- | 46-6/34-11 | Us, Jeanner | 1 120,19-102 | id granital |
| to lead by the at usit permention, | | 18. CAUSE OF DEATH [Enter only one cause per line for | (a), (b), and (c).] | 1 / Thur | heir | INTERVAL BETWEEN ONSET AND DEATH |
| at tanger of the cree | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | mai ari | crial live | mesor | 1 any |
| sic gae ial, ial, | | DUE TO CAMPA | al octivi | osclerosis | | 1/20/20 |
| phy phy purious property part of the property part | | conditions, if any, which gave rise to immediate (b) | as rest | 6 6 4 6 1 4 3 1 3 | | Mission. |
| Fing fing fing fing the the the the | | cause (a), stating the DUE TO | | | | / |
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| r at r at te he | FICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING T | O DEATH BUT NOT RELAT | TED TO THE FERMINAL DISEA | SECONDITION GIVEN IN PART 1(a | PERFORMED? |
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| YSIC hos is ca ache | | | OGDUDDED LOOP DI LO | F of MUDDY disease from | OOS (Olb. or hours) (Oo | ounty) (State) |
| Eet tee | MEDICAL | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY Hour a.m. While | | E OF INJURY (Home, farm, y, street, office bldg., etc.) | 20f. (City or town) (Co | ounty) (State) |
| State of the State | Æ | | t work | 1/1/ | 1 | |
| No. | | 21. I certify that (I) (this hospital) attended the | | // / 7 / 19 0 | b, to 2/12/, 196 | that (I) (we) last |
| th Short | | saw the deceased alive on A | 19 6 , and that | death occurred at 6 47 | M, from the causes and on | |
| REG IN | | 22a. SIGNATURE | | ATTENDING MED. | STAFF 22b. | OATE SIGNED |
| DIRICAL DIRICA | 1 | | M.D. | PHYS. DIREC | CTOR PHYS. | 11/6/4 |
| E E E | | 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | 2 \ \ 0 | |
| O HOSPITA Page 4 ma O FUNERAL director, p | _ | | | | Sury Just | (04040) |
| Page O FUN direct should | 238 | REMOVAL (Specify) | From Program & A | | 3d. LICATION (City, town or co | ounty) (State) |
| | 24 | FUNERAL DIRECTOR | T- JOHNS | | Y REGISTRAR 25b. REGISTRAL | |
| VR A15 (4) | | 2. J. Welster Fin | ricen a | FER 1 | 7 1000 Polime | a Person |
| 7E 74.0 (9) | , | | | DATE - | · 1000 / | - Company |



MARYLAND STATE DEPARTMENT OF HEALTH OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH hours after death. funeral and PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) COUNTY b. COUNTY a. STATE after comico by the i MARYLAND b. CIT OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWN (If guts)de corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR papers. Page nin 72 hours a filled in l NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) carbon papers. rent, within 72 h d. STREET executed within completely NAME OF Middie DATE Month First Last 4. DECEASED DE event, (Type or print) DEATH AGE (In years IF UNOR 1YEAR IF UNDER 24 HRS. last birthday) Months Oays Hours Min. please remove cal, and in any eve 6. COLOR OR RACE DATE OF BIRTH 8. 7. MARRIED **NEVER MARRIEO** and a WIDOWED DIVORCED ICa. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY (County & State, or foreign country) during most of working life, even if retired) The law requires that the death certificate to YOUSE WIFE physi FATHER'S NAME or removal, MOTHER'S attending phermit. Then CLAL 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address has been signed by the attent as the burial-transit permit. prior to burial, cremation, or i (Yes, no, or unknwn) (If yes give war or dates of service) 18. CAUSE OF DEATH [Enter only one cause per and (c). PART I. DEATH WAS CAUSED BY: O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that to Page 4 may be retained by the hospital or attending physician. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which (b) gave rise to immediate DUE TO (a). stating underlying cause last. CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(8) be detached for use State Dept, of Health certificate 20a. ACCIDENT WAS UNDERLYING DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part 1 or Part 11 of Item 18.) DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) FUNERAL DIRECTOR: After this irector, page 3 should be detach nould be filed with the State Depl MFDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street office bldk., etc.) Hour a.m. Not While 19 at work at work p.m. attended, the 21. I certify that (i) (this hospital) deceased from saw the deceased alive 00 from the causes and on the date stated above. and that death occurred 22a. SIGNATURE 22b. DATE SIGNED MED. OIRECTOR ATTENOING PHYS. STAFF PHYS. M.D. 22d. ADDRESS PHYOICIAN'S director, p NAME (Type) OF CEMETERY OR CREMATORY LOCATION (City, town or county) BURIAL, CREMATION, 2 REMOVAL (Specify) URIAL PEGISTRAR'S SIGNATURE FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b.

IS RESIDENCE

ON A FARM? ND X

Year

ONSET AND DEATH

WAS AUTOPSY

NO F

(State)

PERFORMED?

that (I) (we) last

(State)

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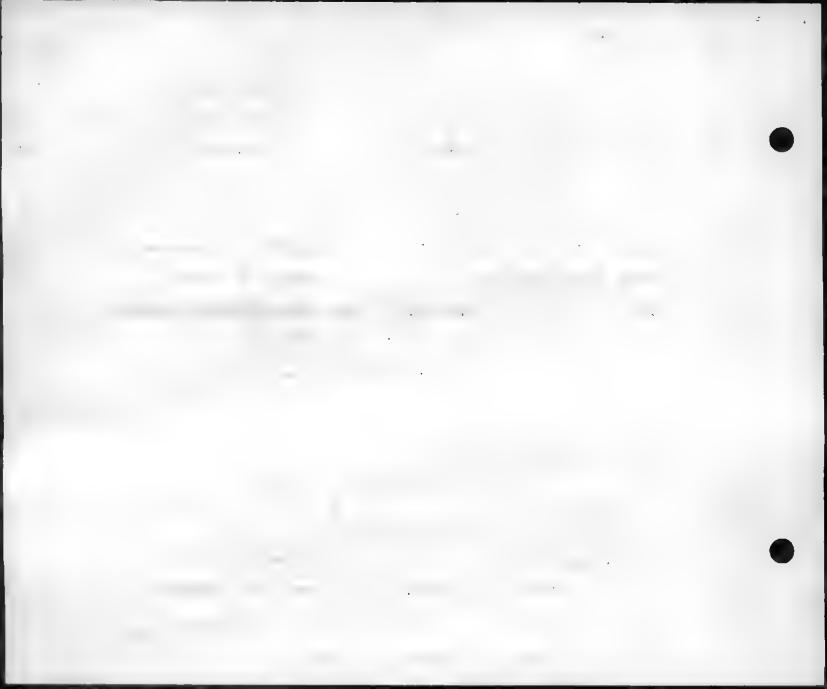
b Q 19

YES

Day

12. CITIZEN OF WHAT COUNTRY?

U.S. A.



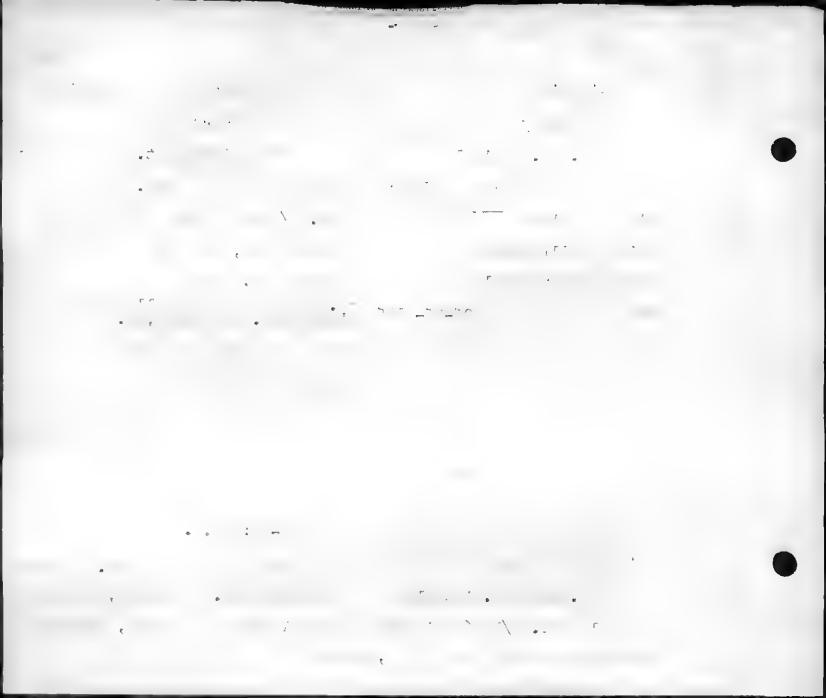
Tage 4 linds be retailed by the hospital of accounting physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, by completely filled in by the funeral director, page 3 should be detached for use as the burnal-transit permit. Then please-remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burnal, cremation, or removal, and in any event, within 72 hours after death THE FIGURE OR STYRMENTS THYSICIAN The law requires that the math certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

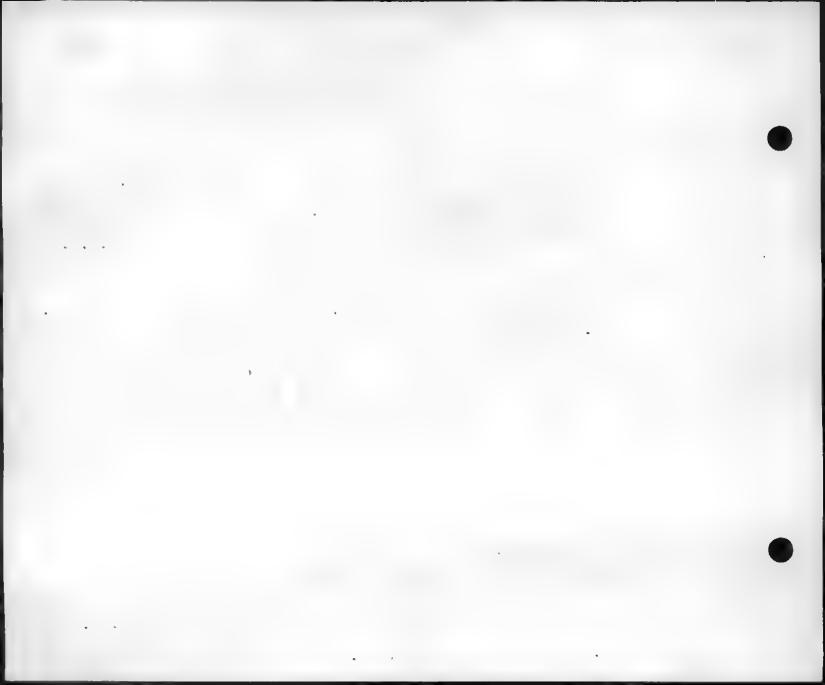
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|--|--------|---|-------------------------------|----------------|-----------------|-----------------------|------------------------|-----------------------------|--|--|--|
| b. CITYOR 100W (if outside corporate limits, write RURAL code property limits, write RURAL and give nearest town) write RUBAL and give nearest town) write RUBAL and give nearest town) write RUBAL and give nearest town) Salisbury O. NAME OF MOSPITAL GR INSTITUTION if not in hospital, give street address) A. SIREET ADDRESS Pem. Gen. Hospital JOSEPH HENRY DOWNELL SALISBURY O. LOST RESIDENCE POWELL S. SAC (in pass; [F HINDERS YEAR) Male OF First HENRY DOWNELL S. SAC (in pass; [F HINDERS YEAR) Month DOWN - 21/1901 S. SAC (in pass; [F HINDERS YEAR) Month DOWN - 21/1901 S. SAC (in pass; [F HINDERS YEAR) Month DOWN - 21/1901 S. SAC (in pass; [F HINDERS YEAR) Month DOWN - 21/1901 S. SAC (in pass; [F HINDERS YEAR) Month DOWN - 21/1901 S. SAC (in pass; [F HINDERS YEAR) Month DOWN - 21/1901 S. SAC (in pass; [F HINDERS YEAR) Month DOWN - 21/1901 S. SAC (in pass; [F HINDERS YEAR) Month DOWN - 21/1901 S. SAC (in pass; [F HINDERS YEAR) Month DOWN - 21/1901 S. SAC (in pass; [F HINDERS YEAR) Month DOWN - 21/1901 S. SAC (in pass; [F HINDERS YEAR) Month DOWN - 21/1901 S. SAC (in pass; [F HINDERS YEAR) Month DOWN - 21/1901 S. SAC (in pass; [F HINDERS YEAR) Month Month DOWN - 21/1901 S. SAC (in pass; [F HINDERS YEAR) Month Month DOWN - 21/1901 S. SAC (in pass; [F HINDERS YEAR) Month Month DOWN - 21/1901 S. SAC (in pass; [F HINDERS YEAR) Month Month DOWN - 21/1901 S. SAC (in pass; [F HINDERS YEAR) Month Month DOWN - 21/1901 S. SAC (in pass; [F HINDERS YEAR) Month Month DOWN - 21/1901 S. SAC (in pass; [F HINDERS YEAR) Month Month Month DOWN - 21/1901 S. SAC (in pass; [F HINDERS YEAR) Month | 1. | PLACE OF DEATH | | 2. USU | AL RESIDENC | E (Where deceased . | lived, If Institution: | Residence before admission) | | | |
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| Pen Gen Hospital 622 Liberty St. YES NOETH NOTE N | | Salisbury | | | Sal | isbury | | 22-1 | | | |
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| DEEASED (Type or print) OSEPH HENRY POWELL DEATH FBB. 24 19 66 | | | | | 622 | Libert | y St. | | | | |
| Type or print) Society Society | 3. | DECEASED | Middle | L, | est | | Month | | | | |
| Male White WIDOWED DIVORCED NOV.21/1901 (6th birthday) Months Day Hours Min. 10a. USALA COCUPATION (Give king of work done and the county of | | (Type or print) JOSEPH | HENRY 1 | POWE | L | | FEB. | 24 19 66 | | | |
| Male winte winder of our control of the winder of the wind | 5. | SEX 6. COLOR OR RACE 7. MARRIED | NEVER MARRIED | 8. DATE | F BIRTH | | | | | | |
| 10a. USAL OCCUPATION (Give kino dwork done due due most of works). He even if reted Relivoadman (NDUSTRY) 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAI COUNTRY! 13. FATHERS NAME W1111am Henry Powell 15. WAS DECEASED EVER IN U.S. RAMED FORCES? (Ct.) 16. SOCIAL SECURITY NO. 17. INFORMANT (Ct.) 15. WAS DECEASED EVER IN U.S. RAMED FORCES? (Ct.) 16. SOCIAL SECURITY NO. 17. INFORMANT (Ut.) | 1 | Male White WIDOWED | DIVORCED 1 | Nov. | 21/190 | 1 64 | | Days Hours Min. | | | |
| As ATTENDED A STATE | 102 | . USUAL OCCUPATION (Give kind of work done) 10b. KI | ND OF BUSINESS OR | 11. BIF | THPLACE (Co | unty & State, or fore | ign country) , 12. C | CITIZEN OF WHAT | | | |
| 14. MOTHER'S MAME 14. MOTHER'S MAIDEN NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EYES IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. WAS DECEASED EYES IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. WAS DECEASED EYES IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. WAS DECEASED EYES IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. WAS AUTOPSY 18. CAUSE OF DEATH (Enter only one cause pet) ine for (a), (b), and (c). 18. CAUSE OF DEATH WAS CAUSED BY. 18. CAUSE OF DEATH (b), and (c). 18. CAUSE OF DEATH (c) 19. WAS AUTOPSY 18. CAUSE OF DEATH (c) 19. WAS AUTOPSY 18. CAUSE OF DEATH (c) 19. WAS AUTOPSY 19. | 1 | COUNTRY? | | | | | | | | | |
| 15. WAS DECEASED PYERINUS. ARMED FORCES? (Vis. no. or unknown) (If yet give war ar date of service) (15. D5. 05. 4735) 18. CAUSE OF DEATH (Entor only one cause per line for (a), (b), and (c).1 PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), at string the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIDUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. of Hem 18.) OR CONTRIBUTING CAUSE OF DEATH OR CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. of Hem 18.) OR CONTRIBUTING CAUSE OF DEATH OR CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. of Hem 18.) OR CONTRIBUTING CAUSE OF DEATH OR CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. of Hem 18.) OR CONTRIBUTING CAUSE OF DEATH NAME (CONTRIBUTING COURRED) 200. PRINCE OF INJURY (Home, farm, 201. (City or town) (County) (State) While Not While at work at wor | | | | | | | | | | | |
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| gave rise to immediate course (a), stating the DUE TO underlying cause last. (c) PARTIL OTHER SIGNIFICANT CONDITIONS CONTRIDUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. (a) 19. WAS AUTOPSY PERFORMED? YES NO X OR CONTRIBUTING CAUSE OF DEATH II. (b) DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) 20a. ACCIDENT WAS UNDERLYING CALL 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) N/A 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 at work at | 1 | DDL 10 | | | | // | | | | | |
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| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, officebidg., etc.) 21. I certify that (I) (this hospital) attended the deceased from 7/20 ADD 10 M, Ifom the causes and on the date stated above. 22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type) 22c. PHYSICIAN'S NAME (Type) 22d. Addrew C. Mitchell 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 24. FUNERAL DIRECTOR ADDRESS PHYSICIAN'S NAME (Type) PHYSICIAN'S NAME (Type) AND PHYS. 22d. ADDRESS PHYSICIAN'S NAME (Type) ADDRESS 25a. REC'D BY REGISTRAR'S SIGNATURE 25b. REGISTRAR'S SIGNATURE | CEE | (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 7/20/65 19 10 M , 19 , that (I) (we) last saw the deceased alive on 2/24/1966, and that death occurred at M, from the causes and on the date stated above. 22a. SIGNATURE M.D. ATTENDING MED. STAFF PHYS. Feb. 26/1966 22c. PHYSICIAN'S NAME (Type) Andrew C. Mitchell Maryland Ave. Salisbury, Maryland 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) PHYSICIAN'S NAME (Type) Andrew C. Mitchell Maryland Ave. Salisbury, Maryland 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) PHYSICIAN'S NAME (Type) Andrew C. Mitchell 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) PHYSICIAN'S NAME (Type) Andrew C. Mitchell 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) PHYSICIAN'S NAME (Type) Andrew C. Mitchell 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) PHYSICIAN'S NAME (Type) Andrew C. Mitchell 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) PHYSICIAN'S NAME (Type) Andrew C. Mitchell 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) PHYSICIAN'S NAME (Type) Andrew C. Mitchell 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) PHYSICIAN'S NAME (Type) Andrew C. Mitchell 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) PHYSICIAN'S NAME (Type) Andrew C. Mitchell 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) | AL | | JURY OCCURRED 20e. PLAI | CE OF INJ | JRY (Home, far | m. 20f. (City o | r town) (Co | unty) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 7/20/65 19 10 M , 19 , that (I) (we) last saw the deceased alive on 2/24/1966, and that death occurred at M, from the causes and on the date stated above. 22a. SIGNATURE M.D. ATTENDING MED. STAFF PHYS. Feb. 26/1966 22c. PHYSICIAN'S NAME (Type) Andrew C. Mitchell Maryland Ave. Salisbury, Maryland 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) PHYSICIAN'S NAME (Type) Andrew C. Mitchell Maryland Ave. Salisbury, Maryland 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) PHYSICIAN'S NAME (Type) Andrew C. Mitchell 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) PHYSICIAN'S NAME (Type) Andrew C. Mitchell 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) PHYSICIAN'S NAME (Type) Andrew C. Mitchell 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) PHYSICIAN'S NAME (Type) Andrew C. Mitchell 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) PHYSICIAN'S NAME (Type) Andrew C. Mitchell 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) PHYSICIAN'S NAME (Type) Andrew C. Mitchell 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) PHYSICIAN'S NAME (Type) Andrew C. Mitchell 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) PHYSICIAN'S NAME (Type) Andrew C. Mitchell 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) | FDIC | 111110 | Not While factor | ry, street, | ffice bldg., et | c.) | ,, | (, | | | |
| saw the deceased alive on 2/24/ 1966, and that death occurred at M, from the causes and on the date stated above. 22a. SIGNATURE M.D. ATTENDING MED. STAFF PHYS. Phys. Feb. 26/1966 22c. PHYSICIAN'S NAME (1202) NAME (1202) NAME (1202) PHYSICIAN'S NAME (1202) NAME (| Σ | | | 1/2 1 | 1-1- | | | | | | |
| 22a. SIGNATURE M.D. ATTENDING MED. DIRECTOR PHYS. 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (1yoe) DP. Andrew C. Mitchell Maryland Ave. Salisbury, Maryland 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY REMOVAL (Spacify) Feb. 27/1966 Wicomico Memorial Park Salisbury, Maryland 24. FUNERAL DIRECTOR ADDRESS ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE ADDRESS ADDRESS ADDRESS ADDRESS ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | 7/2 | | 1291 | 100-12 | 10P.M. | | | | | |
| M.D. ATTENDING MED. STAFF PHYS. Feb. 26/1966 22c. PHYSICIAN'S NAME (Type) NAME (Type) Andrew C. Mitchell Maryland Ave. Salisbury, Maryland 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) EMPLIAL (Spacify) Peb. 27/1966 Wicomico Memorial Park Salisbury, Maryland 24. FUNERAL DIRECTOR ADDRESS AD | | | 19\circ_, and that | death or | curred at | M, from the | | | | | |
| 22c. Physician's NAME (1902) Dr. Andrew C. Mitchell Maryland Ave. Salisbury, Maryland 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Spacify) Feb. 27/1966 Wicomico Memorial Park Salisbury, Maryland 24. FUNERAL DIRECTOR ADDRESS 25a REC'D BY REGISTRAR' 25b. REGISTRAR'S SIGNATURE HOLLOWAY A COMPANY SALISBURY MARYLAND | | (Acmitilu | Y M.D | ATTEN PHYS. | DING N | | 155 | | | | |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (SPACIFY) Feb. 27/1966 Wicomico Memorial Park Salisbury, Maryland 24. FUNERAL DIRECTOR ADDRESS 25a REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE HOT LOWAY A COMPANY SAT LERSIBLY MARYLAND | | 22c. PHYSICIAN'S | | 22d. | ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) BURIAL (Spacify) Feb. 27/1966 Wicomico Memorial Park Salisbufy, Maryland 24. FUNERAL DIRECTOR ADDRESS 25a REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | Dr. Andrew C. Mit | chell | Mary | land. | Ave. Sa | lisbury. | Maryland | | | |
| Burial Saciny Feb. 27/1966 Wicomico Memorial Park Salisbufy, Maryland 24. FUNERAL DIRECTOR ADDRESS | 23a | BURIAL, CREMATION, 236. DATE THEREOF | 23c. NAME OF CEMETERY | OR CREM | ATORY | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS 25a REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE HOT TOWAY & COMPANY SAT TODITON MADVI AND | | Burial Feb. 27/1966 | Wicomico Me | emori | al Pa | 1 | | | | | |
| HOLLOWAY & COMPANY SALISBURY MARYLAND | 24. | | | | | | | | | | |
| The state of the s | F | HOLLOWAY & COMPANY SA | LISBURY, MARY | YLANI | DATE | M 12 12 | | * . 0 . / * | | | |

VR A15 (4) 20M 1/65



TO HOPPITAL LANGUENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may "Latined by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove canon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event withir 72 hours after dept.

| | | DIVISION OF STATISTICAL RESE | ARCH AND RECORDS | S, 301 W. PRESTO | NEALIN N STREET, BA | LTIMORE 1, M | ARYLAND | |
|----|---------------|--|-------------------------------|------------------------------|------------------------|--|-----------------|-----------------|
| | _ | 93023 _T | CERTIFICAT | E OF DEATH | | St. The state of t | 2003 | |
| | | PLACE OF DEATH | | 2. USUAL RESIDENC | E (Where deceased In | | | lm ission) |
| ı, | | WICOMICO | MARYLAND | ARYLANI |) | SOMERSE | | $\sqrt{}$ |
| | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (If | outside corporate i | Imits, write RURAL | end give neares | t town) |
| | | SALISBURY | 5 YEARS | PRINCE | SS ANNE | | , | |
| , | 7 | d. NAME OF HOSPITAL OR INSTITUTION (if not in hi | ospital, give street eddress) | d. STREET ADDRESS | _ | | e. IS RES | IDENCE FARM? |
| Ì. | | | | | | | | NO 🗌 |
| Į | | NAME OF First DECEASED | Middle | Last | 4. DATE OF | Month | Day Yea | |
| 1 | 5. | (Type or print) PEARL | | WELL 8. DATE OF BIRTH | DEATH | FEB. | 17 196 | |
| 1 | | 7. MAKKIED | HETER MARKIED | FEB.11,188 | last b | Months | Days Hours | Min. |
| | | | IND OF BUSINESS OR | 11. BIRTHPLACE (Co | | nn country) 12, Cl | TIZEN OF WHAT | - |
| | durl | | NDUSTRY | MARYLAN | | CO | S.A. | |
| | 13. | FATHER'S NAME | | 14. MOTHER'S MAID | | 0, | 3 h 3 g 2h g | |
| | | ALLISON HOLLAND | | ELIZABET | H POWEI | T. | | |
| ŀ | 15. | WAS DECEASED EVER IN U.S. ARMED FORCES? 16. | SOCIAL SECURITYNO. 17. | INFORMANT | 10.13 | Address | | |
| | (TE | , no, or unkown) (If yes give war or dates of service) | MR | S_REGINALI | CULLEN | CRISFIE | ELD .MD. | |
| ľ | Ī | 18. CAUSE OF DEATH [Enter only one cause per] | HTE FOR (a), (b), and (c), | 1201 | | | INTERVAL BET | TWEEN |
| - | | PART I. DEATH WAS CAUSED BY: | Lettiple | U/lasto. | ma | | ONSET AND I | 16 |
| | | 3203 X DUE TO | | 8 | | | | |
| H | | Conditions, if any, which gave rise to immediate (b) | | | • | | | |
| 1 | | cause (a), stating the DUE TO | | | | | | |
| 1 | Z | underlying cause last.) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBU | ITIMA TO DESTRUCTION NOT DEL | ATED TO THE TEDRAINAL P | NECKEL CONDITION | CIVEN IN DART 1/3\ | 19. WAS AU | TOPSY |
| 1 | CERTIFICATION | / | DITING TO DEATH BOT NOT KED | SIED TO THE TERMINAL D | NIZEWZE COMPILION | GIVER IIV FARI 1(a) | PERFOR | |
| 1 | E I | 20a. ACCIDENT WAS UNDERLYING [] 20b. | DESCRIBE HOW INJURY OCCU | IRRED (Enter nature of | Infury In Part I or | Part II of Item 18. | | A |
| - | ER | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | PEOUTIPE HOW HEAVE OVER | OHITEST (ENTO) HELETO OF | injury in control | | • | |
| | | | | CÉ OF INJURY (Home, fa | | town) (Cou | nty) (S | State) |
| - | MEDICAL | Hour a.m. White | MOT WALLS - | ory, street, office bldg., e | tc.) | | | |
| 1 | 2 | 21. certify that (I) (this hospital) attend | | 7/8 10 | 95% to | 2/12/19 6 | that (I) (v | ve) las |
| 1 | | saw the deceased alive on | | t death occurred at | | causes and on th | | |
| | | 22a. SIENATURE | | | | 22b. D | ATE SIGNED | |
| , | | Mand Japlan | M.I | D. PHYS. | MED. DIRECTOR PH | 1s. 2/ | 19/66 | |
| | | 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | | | | |
| | 024 | BURIAL, CREMATION, 1 23b. DATE THEREOF | 1 23c. NAME OF CEMETER | V OD COEMATORY | Load LOCATION | N (City, town or cou | 121 (vtn) | tate) |
| | Z38. | REMOVAL (Specify) | | | PRINCES | | ** | (acta) |
| | | FUNERAL DIRECTOR | ADDRESS | SBYTERIAN 25a. RE | C'D BY REGISTRAR | 25b. REGISTRAR' | S SIGNATURE | |
| | | LEVIN R. WILSON PRINCES | SS ANNE, MD. | DAMAF | 7 1 1966 | Milianle | en Judge | - |
| 07 | _ | | 1.29 1.20 | DATE(73) | . 1 | - # | 0 0 | |



FOR STA HEALTH delay is P.M.3. Poge 2, and 3 to State Department of ours ofter deoth.

necessary, please execute the certricate, writing the word "pending" in penal in Item 18. Give Pages 1, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form

5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fire pages 1 and 2 within Health or its designated agent, prior to burial, cremotion, or removal, and in any event within

2

VR A15ME (5)

EMOVA. (Specify)

This certificate sllould be axecuted within 24 hours after death

TO DIFFITY MEDICAL EXAMINER:

MARYLAND STATE DEPARTMENT OF HEALTH

| | Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|---|--|--|----------------------|-------------------------|----------|---|--|---------------------------|---------------------------------------|--|--|
| | 03024 | | MEDIC | AL EXAMI | NER'S | CERTIFICATE OF | DEATH | {} | 2010 | | |
| | PLACE OF DEATH D. COUNTY | Wicomic | | MAR | YLAND | | nere deceased lived, finistrution Land b. COUNTY | | before admission) Mice | | |
| b. CITY OR TOWN (If autside carparate limits, write RURAL and give pearest town) | | | | | | | ide corporote limits, write RURAI | L ond give n | earest town) | | |
| | d NAME OF HOSPITA | AL OR INSTITUTION (If not | in haspital, give | street gudress) | | d. STREET ADDRESS | | | e IS RESIDENCE | | |
| Peninsula General Hospital | | | | | | | 414 Lake St. ON A FARM? YES NO NO | | | | |
| | NAME OF DECEASED (Type or print) | First K evin | | Middle B yne | Prit | tchett | 4. DATE Month DEATH 2-2 | 3-66 | Day Year | | |
| EMES . | XAS | 6. COLOR OR RACE C | 7 MARRIED WIDOWED | NEVER MARRIE DIVORCE | | B. DATE OF BIRTH 6-19-61 | | IF UNDER 1 YI Manths D | AR IF UNDER 24 HRS. Cays Hours Min | | |
| | USLAL OCCUPATION | (Give kind of work dane lile, even if retired) | 10b. KIND | OF BUSINESS OR | _ | 11 BETHPLACE TSTOTE O | Floreign country) | 12. CITIZE | N OF WHAT | | |
| 13 | 13 FATHER S) NAME POLICE TO THE POLICE OF TH | | | | | | | | | | |
| 15 | 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, 10. oxfork pown) His was greater or dates af service) Address: A | | | | | | | | | | |
| | IB. CAUSE OF DE PART I DEAT | ATH (Enter only one couse H WAS CAUSED BY IMMEDIATE CAUSE (o | Pean | (b), and (c).) domonas | Septi | icemia: | | | NTERVAL BETWEEN ONSET AND DEATH | | |
| | 7/60 DUE TO | | | | | | | | | | |
| | Canditions, if any, which gave has to immediate course (a), (b) Burns of 60 % of body surface | | | | | | | | Li weeks | | |
| | stating the under | | • | | | | | | | | |
| CATION | PART II OTHER SIG | GN FICANT CONDITIONS COM | TR BUTING TO D | EATH BUT NOT RE | LATED TO | THE TERMINAL DISEASE COND | T ON GIVEN N PART 1(a) | | 19. WAS AUTOPSY PERFORMED? YES NO & | | |
| MEDICAL CERTIFICATION | 20o. EXTERNAL CAL PRIMARY E.For CON CAUSE OF DEATH | USE WAS ITRIBUTING [| | | | Enter nature of injury in Pouring house i | | | | | |
| 3 | | RY Manth, Doy, Year | 20d NuuR | Y OCCURRED | 20e PLA | CE OF INJURY (Home, farm | 20f (City or fown) | (County | y) (Stote) | | |
| MED | P.M. | 12-27-65 | While at work | Not While of work | OWI | ory, street, office bldg., etc.) | Salisbury W | icanio | o Md. | | |
| 21 certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry A, and in my opini | | | | | | | | and in my opinion | | | |
| | death result | ed from. Notural | causes | Accident X | Suic | ide 🔲, Homicide [| , Undetermined mor | nner 🔲 | | | |
| | ACTUAL SIGNATURE | Enfe | R | | | CHIEF MEDICAL EX | AL EXAMINER | | 22. DATE SIGNED | | |
| | EXAMINER'S E | Earl L. Roye 109 Camden A | | lishuw | Ma | DEPUTY MEDICAL | EXAMINER TOURTY) | 2- | -2466 | | |
| 230 | BUDIAL CREMATIO | 23h DATE THED | OF 7 | 2. NAME OF THE | CTEDY OR | CDEMATORY | 22 JOCATION (City of Town | 1 21 11- | umbile (State) | | |

Cery

2Sa

DMAR

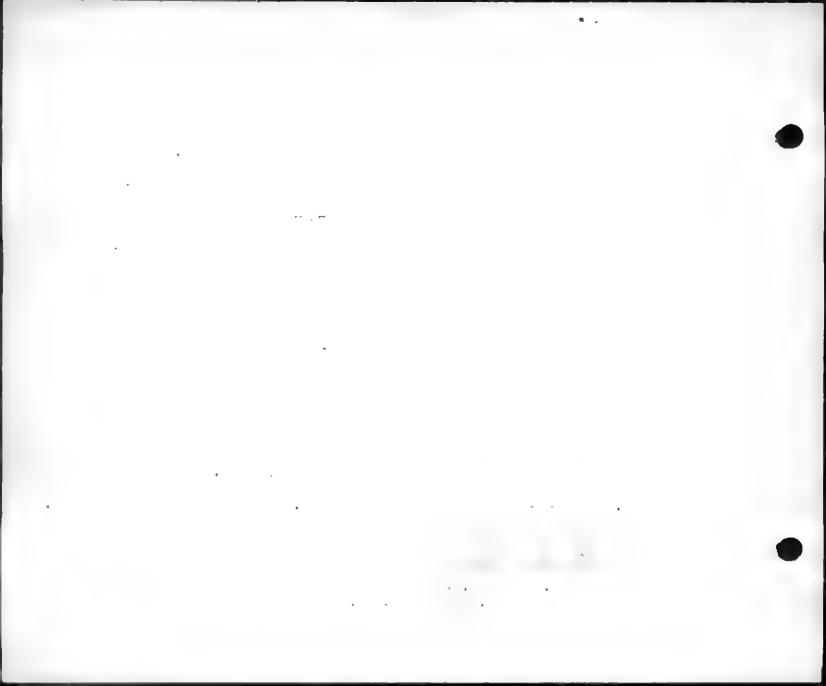
ADDRESS

REC'D BY REGISTRAR

REGISTRAR S SIGNATURE

25b.

1956



TO MOSPITAL OF ITTENDING PHYBEIAT The law requires that the death cartificata be executed within 24 mean after death.

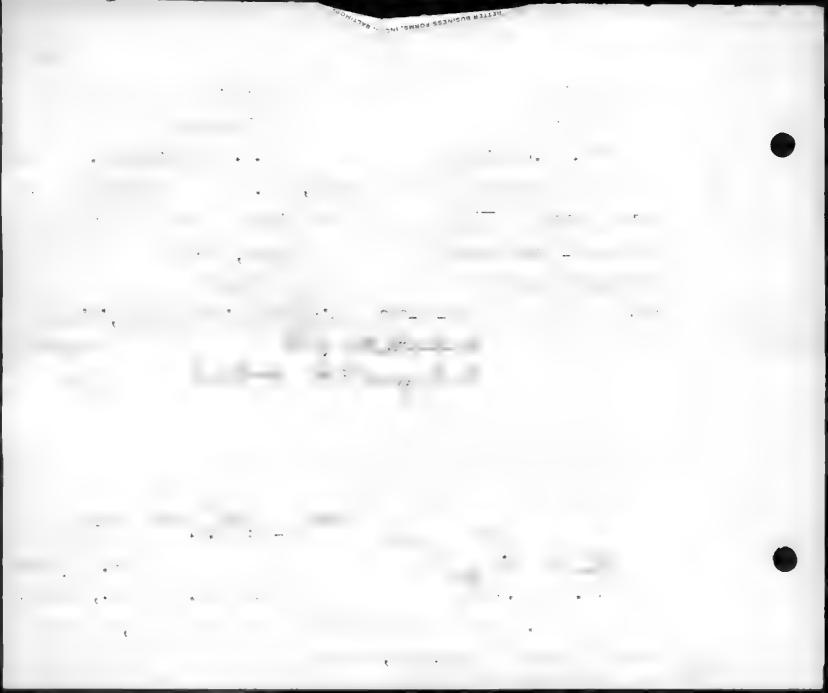
The may be retained by the hospital or attending plysician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove completion papers. Pages 1-red 2 should be filed with the State Dept, of Health prior to burial, cremation, or removal, and in any event, within 72 hours after ceath.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

| | L.3(.2) CERTIFIC | LAIL | C UP DEATH |
|-----------|--|---------|--|
| 1. | PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) |
| | a. COUNTY Wicorico MARYL | AND | a. STATE Maryland b. COUNTY Wiconico |
| | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| | write RURAL and give nearest town) Salisbury | d==== | Salisbury |
| | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street add | aress) | d. STREET ADDRESS 6. IS RESIDENCE DN A FARM? |
| 2 - | Pem.Gem.Hospital | - | R.D.#4 Cardinal Dr. VES NO |
| 3. | NAME OF First Middle DECEASED (Type or print) ANDREW LEE | DII | Last 4. DATE Month Day Year |
| 5. | (Type or print) ANDREW LEE 6. COLDR OR RACE 7. MARRIED NEVER MARRIED | | SEY, SR. DEATH FEBRUARY 8 19 66 B. DATE OF BIRTH 19. AGE (IN years IFUNDER 1 YEAR IFUNDER 24 HRS. |
| | Male White WIDOWED DIVORCED | | last birthday) Months Days Hours Min. |
| l0a | USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS DR | | May 5/1936 29 yrs. 9 3 |
| ari | Ing most of working life, even if retired) Salesman - Tire Store | | Salisbury Maryland U.S.A. |
| 13. | FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME |
| | Marion Lee Pusey | I | Addie Parsons |
| 15. Ye | . WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY ND. is, no, or unknown) ((if yes give war or dates of service) | Man | INFORMANT S. Rebecca H. Pugey (Wife) R.D.#4 |
| | Yes 219-34-3638 | Ca | reinal Drive Salisbury Maryland |
| 1 | 18. CAUSE DF DEATH (Enter only one cause per line for (a), (b), and (c), | 3 | 21801 INTERVAL BETWEEN ONSET AND PAIR |
| | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | لسو | Civi humble |
| | Conditions If any which I | 00 | A Jest D |
| - | Conditions, If any, which gave rise to Immediate (b) | ~ \ | The state of the s |
| | cause (a), stating the DUE TO | | U |
| 5 | PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO | T RELAT | TED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTDPSY |
| 3 | | | PERFORMED? YES ND P |
| | 20a. ACCIDENT WAS UNDERLYING [] 20b. DESCRIBE HOW INJURY | Y OCCUP | RRED. (Enter nature of injury in Part i or Part ii of item 18.) |
| 3 | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | |
| 12. | Mann a m | e. PLAC | CE OF INJURY (Home, farm, 20f. (City or town) (County) (State) y, street, office bidg., etc.) |
| E. | p.m. 19 While Not While at work | | |
| | 21. I certify that (I) (this hospital) attended the deceased fro | /111 | 19 55 to 2 , 19 CC, that (I) (we) last |
| | saw the deceased arive on 19CC, and 22a. SIGNATURE | d that | death of the date stated above. |
| | ZZG. SIGNATURE O | | ATTENDING A MED. STAFF TO BOL 10 /2066 |
| | 220 PHYSICIAN'S | M.D. | PHYS. A DIRECTOR L PHYS. PHYS. 1900 |
| İ | NAME Dr. Earl L. Rover | | 409 Camden Ave. Salisbury, Maryland |
| 3a. | BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEM | METERY | |
| | Burrareity Feb. 11/1966 Wicomico | Mei | morial Park Salisbury, Maryland |
| | FUNERAL DIRECTOR ADDRESS | | 1 252. REC'D BY REGISTRAR 250. REGISTRAR'S SIGNATURE TAND FFR 1 5 1968 Phanles Judge |
| ri! | OLLOWAY & COMPANY SALISBURY, M. | ARY. | LAND DATE EB 15 1968 flance Judge |

VR A(5 (4) 20M 1/65

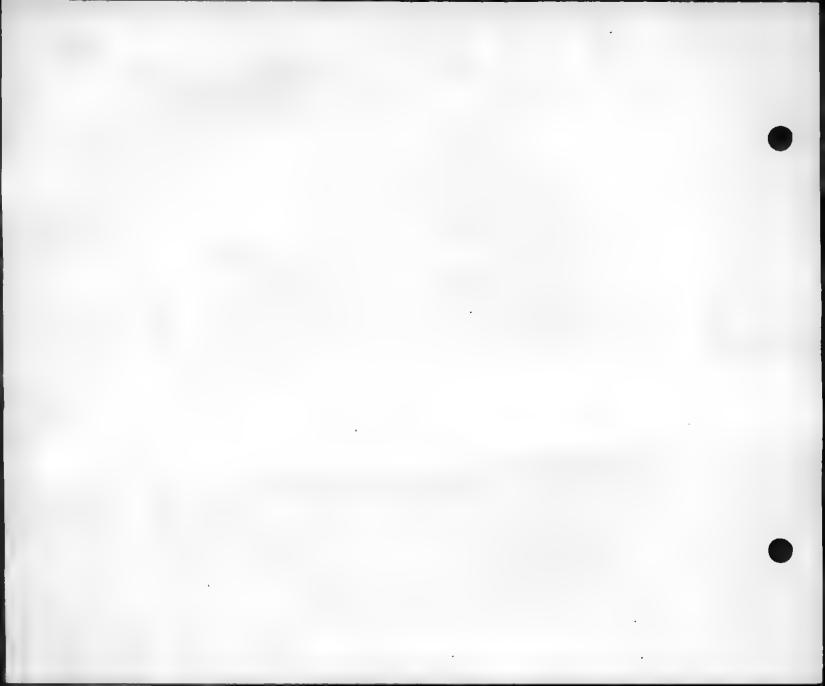


TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 And 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after deal to the state beat after deal to the state beat. 24 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Page 4 may be retained by the hospital or attending physician.

> VR A15 (4) 15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| 1. PLACE OF DEATH 8. COUNTY | 2. USUAL RESIDENCE (Where deceased lived, If institution: Re | esidence before admission) | | |
|--|--|-------------------------------|--|--|
| | a. STATE DEL ALDOSE b. COUNTY | SCEN J | | |
| b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL | and give nearest town) | | |
| (Write, RURAL and give nearest town) | | 11 0 | | |
| DA/ISBURY | OFORGE OWN | 46-5 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | d. STREET ADDRESS | 6. IS RESIDENCE ON A FARM? | | |
| Teninsula General Nongeta! | | YES NO | | |
| 3. NAME DF First Middle | Last 4. DATE Month | Day Year | | |
| (Type or print) Kittie Ellen | PUSKY DEATH FEFRUARY | 10 19 66 | | |
| 5. SEX 6. CDLOR OR RACE 7. MARRIED NEVER MARRIED | 8. DATE OF BIRTH 9. AGE (In years IF UNDER) | | | |
| Finale WIDOWED DIVORCED | 5-25-1898 last birthday) Months | Days Hours Min. | | |
| 1Da. USUAL DCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of working life, even if retired) INDUSTRY | | TIZEN OF WHAT | | |
| during most of working life, even if retired) INDUSTRY | DET AT JADE | INTRAT- | | |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | | | |
| 1 | I DA ADKINS | | | |
| CLAYTON ADRINS | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. | INFORMANT TO Address | 17 | | |
| NC 1 22-16-1946 | FAUL TUSEY, GETREE | TOWN, DEZ. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN | | |
| PART I, DEATH WAS CAUSED BY: Carcin materia | | ONSET AND DEATH | | |
| IMMEDIATE CAUSE (a) | ^ | | | |
| Conditions, if any, which i Carcingma of of | Le Ball Bladder | 1 years? | | |
| gave rise to immediate (b) | 2 10000 1000 | - | | |
| cause (a), stating the DUE TO | | | | |
| underlying cause last.) (c) | | Teo Wile AllTopov | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA | TED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(8) | 19. WAS AUTOPSY PERFORMED? | | |
| V one | | YES NO NO | | |
| 20a, ACCIDENT WAS UNDERLYING [7 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part or Part or Part of Item 18.) | | | | |
| | | | | |
| 191 | CE OF INJURY (Home, farm, 20f. (City or town) (Courty, street, office bidg., etc.) | nty) (State) | | |
| Hour a.m. While Not While at work at work | 13) actions on the Britania | | | |
| 21. I certify that (I) (this hospital) attended the deceased from | 7 Feb 1966 to 10 Feb 196 | 6, that (I) (we) last | | |
| saw the deceased alive on 10 February attended the deceased nothing | t death accurred at 6 % M from the causes and on the | he date stated shove. | | |
| 22b DATE SIGNED | | | | |
| 1 - 1 C V-1 - 1 08 | ATTENDING MED. STAFF | | | |
| 22c, PHYSIGIAN'S | DIRECTOR PHYS. | | | |
| NAME (Type) | Medical Conter Interben | y Maryland. | | |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) | | | | |
| REMOVE (Specify) 7 = 17-1/1 MILLIST, RA ASM MILLISTERS ASM | | | | |
| 24 FUNERAL DIRECTOR // S. ADDRESS (. C. 125a. REC'D BY REGISTRAR'S SIGNATURE | | | | |
| The state of the s | | | | |
| UITHEROS THEREN, J. TORRIOTE, Wester | use of B 14 1966 I marle | Judge | | |



THERETY MENION—EXAMINER, This certificate with the mount of within 21 haum after death. If any delay indicasery, these execute the certificate, writing the word "bending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. with the State Department with 12 hours after death. TO FUNERAL DIRECTOR: Page 3 should be used as a burlal-transit permit. File pages 1 and of Health or its designated agent, prior to burial, cremation, or removal, and in any event

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

| | 33027 | MEDICAL EXAMINER'S | S CERTIFICATE OF DEATH | 15,013 |
|--|--|--|--|--|
| 1. | PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Re | esidence before admission) |
| | Wicomico | MARYLAN | a. STATE Ilary Land b. COUNTY Wic | omico |
| | b. CITY OR TOWN (If cutside cor write RURAL and give neares | porate limits, c. LENGTH OF STAY IN | 26 C. CITY OR TOWN (If outside corporate limits, write RURAL | and give nearest town) |
| | Salisbury | 5 ons | Sa lisbury | + ! |
| | d. NAME OF HOSPITAL OR INSTIT | IUTION (if not in hospital, give street addre | | e. IS RESIDENCE ON A FARM? |
| 1 | 635 W. Main St. | | 635 W. Main St. | YES NO NO |
| 3. | NAME OF DECEASED | First Middle | Last 4. DATE Month | Day Year |
| | (Type or print) Bli | zabeth | Reed DEATH 2-9-66 | 19 |
| 5. | SEX 6. COLOR OR R | ACE 7. MARRIET NEVER MARRIED | 8. DATE OF BIRTH 9. AGE (In years IF UNDER last birthdey) Months | 1 YEAR IF UNDER 24 HRS. Days Hours Min. |
| | FC | WIDOWED DIVORCED | 14-10-44 21 yrs. | |
| 1Da | I. USUAL OCCUPATION (Give kind of ing most of working life/even if r | etired) INDUSTRY . | | TIZEN OF WHAT |
| | Domestic | mone | dance hel a | SA |
| 13. | FATHER'S NAME | | 14. MOTHER'S MAIDEN HAME | |
| | anonto | 7 | plany Common | |
| (Yi | . WAS DECEASED EVER IN U.S. ARM es, no, or unknown) (If yes give war or d | ED FORCES? 16. SOCIAL SECURITY NO. lates of service) | 17. INFORMANT | |
| <u></u> | | | John Mary Feled | |
| | 18. CAUSE OF DEATH [Enter on PART I. DEATH WAS CAUSE | ly one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH |
| | IMMEDIATE CA | | | Minutes |
| | 1100 | DUE TO | | |
| | Conditions, if any, which gave rise to immediate? | (b) Carbon monoxid | le poisoning | |
| | cause (s), stating the | DUE TO | | |
| 2 | underlying cause last. | (C) | RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | 19. WAS AUTOPSY |
| 110 | PARTITIOTHER STORTFTOART CON | MENTED TO THE LEMMING DISEASE ON DIVINOUS STATE OF THE PARTY AND THE | PERFORMED? | |
| WEDICAL CERTIFICATION | 20a EYTEDNAL CALLEE WAS | 10h Describe now inition | OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18. | YES NO T |
| E | 2Ds. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING (CAUSE OF DEATH. | D ZOU. DESCRIBE NOW WHICH I | | , |
| 10 | 20c. TIME OF INJURY Month. | TTGUIGU III IIO | use during a hou sefire. PLACE OF INJURY (Home, farm, 2Df. (City or town) (Cou | ntv) (State) |
| 200 | Hour a.m. | While - Not While | actory, street, office bldg., etc.) | |
| Z | 8:30 An N 2-9- | | Home Salisbury Vicomia Salisbury Vicomia | and in my ppinion |
| | A . | harge of the remains described above, | | and in my phinton |
| | death resulted from. Na | tural causes, Accident X, | Suicide, Undetermined manner CHIEF MEDICAL EXAMINER [| |
| | ACTUAL / | 1 1/2 / | M.D. ASSISTANT MEDICAL EXAMINER | 22. DATE SIGNED |
| | SIGNATURE | | DEPUTY MEDICAL EXAMINER 2-10-66 | 4 |
| | EXAMINER'S Earl L. | Royer, In (2) | Address (Street, city, town, or county) | 3 |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETER OR CREMATORY 23d. (LOCATION (City, town or county) (St | | | | |
| 1 | Secretary 2- | 13 661 Dream | stores Selesting | The |
| 24 | FUNERAL DIRECTOR | ADDRESS | 258. REC'D BY REGISTRAR 251. BEGISTRAR | SIGNATURE |
| | 6 Je-100 1 71 | 7-11.01 | PATES 15 1986 / 1200le | y Judge |

VR AISME (5) 1/65



used as a burial-transit to burial, cremation, or

TO FUNERAL DIRECTOR: Page 3 should be of Health or its designated agent, prior

VR ALSME (50)

03

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 123 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| Z | . PLACE OF DEATH | mil | | | sidence before admission) |
|---------------|---|--------------------------------------|---------------------------------------|-----------------------------|-------------------------------|
| | | MARVIAND | Mary and | | nico |
| | b. City OR TOWN (If outside corporete limi | ts, c. LENGTH OF STAY IN 15 | | | |
| | ~ ~ ~ ~ | Like | Salishum | | 4 |
| | | ot in hospital, give street address) | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? |
| | 635 W. Main St. | | | | YES NO X |
| 3 | DECEASED | Middle | OF. | | |
| 5 | 0.00 | BBIED NEVER MARRIED ST | 8. DATE OF BIRTH 9. | AGE (In years IF UNDER 1 | |
| | 1 | | 1-18-1964 2 | lest birthday) Months | Days Hours Min. |
| 100 | uring most of working life, even if retired) | INDUSTRY | 11. BURTHPLACE (State or foreig | COI | UNIBAS |
| _ | | mone | LIA MOTUEDIS MAIDEN NAMES | a | 517 |
| ľ | | | | | |
| Ь | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 17. | | Address | - |
| 1 | Yes, no, or smkgown Or yes give war or dates of service | more 71 | no Mory Teed | } | |
| - | 18. CAUSE OF DEATH [Enter only one caus | e per line for (a), (b), and (c).] | | • | INTERVAL BETWEEN |
| П | PART I. DEATH WAS CAUSED BY: | Asphyxia | / | | Linutes |
| П | (111 A | IND DILYBEAC | | | |
| L | Conditions If any which ! | Camban manari | de peigening | | 11 |
| | geve rise to immediate | Carbon monoxi | de horsourns | | |
| | conso (a) storing me | | | | |
| L | 1 14/ | | | | - TO THE THEODON |
| 3 | PART II. OTHER SIGNIFICANT CONDITIONS CO | NTRIBUTING TO DEATH BUT NOT REL | TED TO THE TERMINAL DISEASE CONS | ITION GIVEN IN PART 1(a) | PERFORMED? |
| 15 | | | | | YES NO X |
| PEDTIFICATION | 208. EXTERNAL CAUSE WAS | 20b. DESCRIBE HOW INJURY OCCU | IRRED. (Enter nature of Injury in Par | t or Part of Item 18.) |) |
| 18 | PRIMARY AN OF CONTRIBUTING D | Transad in hour | a during a housafi | 200 | |
| 1 | 20c. TIME OF INJURY Month, Day, Year | 20d. INJURY OCCURRED 120e, PLA | CE OF INJURY (Home, farm, 20f. (C | Olty or town) (Cour | nty) (State) |
| MEDICAL | Hour a.m. | While - Not While factor | ry, street, office bldg., etc.) | | ico 11d. |
| 2 | | | | | and in my opinion |
| L | | | | | |
| L | l 1. | 7 | CHIEF MEDICAL EXAMINER | | |
| l | ACTUAL | M | | | 22. DATE SIGNED |
| | | r, M.D.X | Δ. | VE V 2= | 10-66 |
| 1 | a. SOLINY NI COMICO D. CHY OR TOWN (If Outside corporate limits, write RURAL and give nearest town) Will COMICO D. CHY OR TOWN (If Outside corporate limits, write RURAL and give nearest town) Salisbury d. NAME OF HOSTITULION (If not in hospital, give street address) Salisbury d. STREET ADDRESS SOLING THE MOOTH CASH DEPTH OF PIRIT | | | | |
| ľ | (: REMOVAL (Specify) | 1- 1631 12 1 | feres Cen Sal | Isterny - | me . |
| 1 | | | 25a. REC'D BY REGIS | TRAR 25b. REGISTRAR'S | S SIGNATURE |
| | atooper M | West | SEB 1 5 19 | 56 Thanks | Judge |



TO DEPUTY MED.—EXAMINER. This certificate should be executed within 24 hours after death. If any delay, secessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burlal-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burlal, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | OCITIONE OF PARTY | (3 45 () |
|---|--|---------------------------------|
| 1. PLACE OF DEATH | 2. USUAL RESIDENCE (Where deceased lived, If Institution: R | esidence before admission) |
| Wicomico MARYLAND | a. STATE Marryland b. CDUNTY | Wicomico |
| | c. CITY OR TOWN (If outside corporete limits, write RURAL | and obtaining the service town) |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | alia Risa lical est famili |
| Salisbury US | Salisbury | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | d. STREET ADDRESS | e. IS RESIDENCE ON A FARM? |
| 635 W. Main St. | 635 W. Main St. | YES ND |
| 3. NAME OF First Middle | Last 4. DATE Month | Day Year |
| DECEASED (Type or print) Mark | Reed DEATH 2-9 | - 66 ₁₉ |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 1 | 8. DATE OF BIRTH 9. AGE (in years IF UNDER Last birthday) Months I | |
| M C WIDOWED T DIVORCED TO | 12-15-64 Jast birthday) Months | Days Hours Min. |
| 10e. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR | | TIZEN OF WHAT |
| during most of working life, even if retired) INDUSTRY | So Pesture 8 | DAN LANS WILL |
| none none | | C'D.1 |
| 13. FATHER'S NAME | 14. MÖTHER'S MAIDEN NAME | |
| Nathan Reed | Elizabeth \(\) | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. | INFORMANT Ardress | |
| (Yes, no, or linkown) (189/es give war or dates of service) None | I'm Illory Read | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Asphyxia | | PUNSET AND DEATH |
| DUE TO | | |
| Conditions if any which t | noigoning | 11 |
| gave rise to immediate | <u>fortsofttins</u> | |
| cause (a), stetling the DUE TO | | |
| underlying cause lest.) (c) | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA | TED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) | 19. WAS AUTOPSY PERFORMED? |
| CAT | | YES NO X |
| PARTIL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA 20a. EXTERNAL CAUSE WAS PRIMARY TO OF CONTRIBUTING CO CAUSE OF DEATH. Trapped in house | IRRED. (Enter nuture of injury in Part I or Pert II of Item 18 | .) |
| 20m. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCU PRIMARY FG OF CONTRIBUTING [| during a hougafine | |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLA | during a housefire. CE OF INJURY (Home, farm, 20f. (City or town) (Cot | inty) (State) |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLAN Hour e.m. While Not While at work Ho | ry, street, office bldg., etc.) | |
| 8:30 April 2-9-66 at work at work M Ho | me Salisbury Wive | mico Md. |
| 21. I certify that I took charge of the remains described above, hel | d an Autopsy , Inspection , Inquiry , | and in my opinion |
| death resulted frace? Natural causes []. Accident [X] Sui | cide . Homicide . Undetermined manner | |
| | CRIEF MEDICAL EXAMINER | |
| ACTUAL . | M.D. ASSISTANT MEDICAL EXAMINER | 22, DATE SIGNED |
| SIGNATURE | DERUTY MEDICAL EXAMINER | |
| EXAMPLET'S EXVIL, RODEV 409 | Address (Street, city, told), or county | 2-10-11 |
| | OR CREMATORY 23d LOCATION (CID Own or con | unty) (State) |
| Jemovic (3000 (1)) 2-12-66 Gran / | Leres Salvalesces | S SIGNATURE |
| 24. FUNANA DIRECTOR ADDRESS | FED A THE PART OF A | ` n . |
| Door // Cer | DATE B 15 1966 Jackenle | Judge. |
| | | -0 |



please execute the certificate, writing the word "pending" in mention 14 hours after death. If any delay is constant, please execute the certificate, writing the word "pending" in mention in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Department after deathy State hours File pages 1 and 2 with the and in any event within 72 permit. F TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit of Health or its designated agent, prior to burial, cremation, or

BE ALSMEN (8)

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND,

| | | 03630 | MEDICAL | EXAMINER'S | CERTIFICATE | OF DEATH | 1 | 00016 |
|---|---------------|--|--|------------------------------|-------------------------------|--------------------------------|-------------------|-------------------------------------|
| 1 | 1. | PLACE OF DEATH | mico | | 2. USUAL RESIDENC a. STATE | | COUNTY | sidence before admission) |
| 1 | - | | | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (IF | Maryland outside corporate lim | | and give nearest town) |
| | | b. CITY OR TOWN (If outside cor write RURAL and give neares | t town) | 1010 | | | , | <i>j</i> |
| | - | Salisbury d. NAME OF HOSPITAL OR INSTITUTE | TUTION (If not in hos | spital, give street address) | Salisbu | rry | | I e. IS RESIDENCE |
| | | | | Elenit Gire emane Managai | | illustra Cub | | ON A FARM? |
| | 3 | 635 W. Hain St. | First | Middle | 635 W. N | 4. DATE | Month | YES NO |
| | ٠, | DECEASED | LH2F | | Lest | OF DEATH | 2-9-66 | |
| | 5. | TA CTUTIONI | ACE 7 MADDIED F | X NEVER MARRIED | 8. DATE OF BIRTH | 9 AST (In | VAARS LIFTINDER 1 | 19 YEAR FUNDER 24 HRS |
| | | 11 0 | WIOOWED [| OIVORCED | 1 10 | Set Ziast birt | nday) Months | Days Hours Min. |
| | 10a | . USUAL OCCUPATION (Give kind of | | ND OF BUSINESS OR | 7 | tate or foreign country | yrs. | TIZEN OF WHAT |
| | dur | Ing most of working life, even it r | effred) INC | cone (| Saleot | eury | COL | UNTERV? B |
| C | 131 | FATHER'S NAME - Cox Cox Te | ed | | 14 MOTHER'S MAID | EN NAME | ancer | J |
| | 15 (Y | WAS DECEASED EV RINUS. ARM | | OCIAL SECURITY NO. 17. | INFORMANT | e Poll | Address | |
| | | N NO MI | F- 1,</td <td>1595 M</td> <td>2110 2010</td> <td>a rage</td> <td></td> <td></td> | 1595 M | 2110 2010 | a rage | | |
| | | 18. CAUSE OF DEATH [Enter on PART I. DEATH WAS CAUSE | | e for (a), (b), and (c).] | / | | | INTERVAL BETWEEN ONSET AND DEATH |
| | | IMMEDIATE CA | | hyxia | | | | Minutes |
| ļ | | 1100 | OUE 10 | | | | | |
| | | Conditions, if eny, which agave rise to immediate | (b) Car | bon monoxide | poisonin g | | | |
| | | cause (e), stating the | DUE TO | | | | | |
| | z | underlying cause lest. PART II. OTHER SIGNIFICANT CON | (c) | INC TO DEATH BUT NOT BELL | TED TO THE TERMINAL D | ISEASE CONDITION OF | (EN IN PART 1/a) | 119. WAS AUTOPSY |
| | CERTIFICATION | | DATIONS CONTRIBUT | Ma 10 DESTRIBUTION RED | TIED TO THE JERMINALD | ISEASE CONDITION ON | DI HIT ACT 1(0) | PERFORMED? YES NO X |
| | ERTIF | 20a. EXTERNAL CAUSE WAS PRIMARY 19 or CONTRIBUTING (CAUSE OF DEATH. | | ESCRIBE HOW INJURY OCCU | | | | |
| | | 20c. TIME OF INJURY Month, | Dey, Yeer 20d. IN. | capped in home | CE OF INJURY (Home, fa. | rm, 20f. (City or to | wn) (Cour | nty) (State) |
| | MFDICAL | Hour a.m. E. 2 ↑ Apun 1 2 → 9 | White at work | NOT WRITE | ory, street, office bldg., et | | urv_Wiebr | - 713 |
| ٠ | Σ | 21. certify that I took cl | | | Id an Autoney | Inspection X, | inquiry X | and in my opinion |
| | | | tural causes . | | icide 🔲, Homiciō | 4.0 | nined manner | |
| | | ACTUAL F | / - | | CHIEF MEDICAL | | | 22. BATE SIGNED |
| | | SIGNATURE | -/~/- | | PVI + Is/+ | DICAL EXAMINER | | 22. BATE SIBNED |
| | | EXAMINER'S Earl L. | Royer, Of | Saliahaan Ma | | AL EXAMINER | 2-10-6 | 66 |
| | 23a | BURIAL CREMATION, 236. | 13-66 | THE WELL | Pares | 23d. YOCATION (C | levery | mty) mc (State) |
| j | 24 | FUNERAL DIRECTOR | m | ADDRESS | 25a. REC | D BY REGISTRAR 25 | b. REGISTRAR'S | SIGNATURE |
| | 6 | 1300 Kes / | 11-100 | 21. | DAFEEB | 1.5 1956 | Planle | Judge. |
| | | | | 4 | | | | 11 |



FOR STATE HEALTH DEPT.

O DEPUTY MENULAL EXAMINED This martificate should be executed within 24 hours after leath. If any dailay accessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. State Department hours after death. permit. File pages 1 and 2 with the removal, and in any event within 77

TO DEPUTY MEDI

1. 3. 5. 10a du 13 15 (Yo TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit of Health or its designated agent, prior to burial, cremation, or MEDICAL CERTIFICATION DEPUTY MEDICAL EXAMINER Royer, (II) D. EXAMINER'S NAME (Type) Address (Street, city, town, or county) BURIAL CREMATION 230. OR REMATORY 23d /LOCATION (Ofty, town or county) 23a. FUNERAL DIRECTOR ADDRESS REC'D BY REGISTRAR 25b. VR ALSME (5) 1956

| | PARTMENT OF HEALTH | |
|--|--|---------------------------|
| Division of STATISTICAL RESEARCH AND RECORDS | | RYLAND |
| ುವರಿತಿ MEDICAL EXAMINER'S | CERTIFICATE OF DEATH | 10017 |
| PLACE OF DEATH | 2. USUAL RESIDENCE (Where deceased lived, If institution: Re | sidence before admission) |
| Wicomico Maryland | a. STATE Maryland b. COUNTY Vice | omico |
| b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (If outside corporate limits, write RURAL | |
| Write RURAL end give nearest town) Salisbury | Salisbury | . / |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | a. IS RESIDENCE |
| 625 W Main St | 635 W. Main St. | ON A FARM? YES NO X |
| NAME OF STATE MIDDLE | Last 4. DATE Month | Day Year |
| DECEASED 11-1- | OF DESCRIPTION OF CALL | 19 |
| SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 | |
| M C WIDOWED DIVORCED | | Days Hours Min. |
| . USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR | 11. BIRTHPLACE (State or foreign country) / 12. Cl | TIZEN OF WHAT |
| ing most of working life, even if retired) INDUSTRY | Salisland md 60 | UNTRYZ |
| FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | C 3 1 3 |
| 37-12 D 1 | The make Water on | |
| Nathan Rood. | INFORMANT Address | |
| ss, no, or unknown) (If yes give war or dates of service) | U | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c), 1 | | INTERVAL BETWEEN |
| PART I. DEATH WAS CAUSED BY: | | ONSET AND DEATH |
| IMMEDIATE CAUSE (e) Asphyxia | | TITUITIOSS |
| Sanditions of any which i | | Ð |
| gave rise to immediate | o poisoning | |
| causa (a), stating the DUE TO underlying causa last, | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT REL | ATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | 19. WAS AUTOPSY |
| | | PERFORMEDTX |
| 208. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCC | URREO. (Enter nature of injury in Part I or Part II of Itam 18.) | |
| PRIMARY TO OF CONTRIBUTING | | |
| 20c, TIME OF INJURY Month, Day, Year I 20d, INJURY OCCURRED 120e, PL | e during a housefire ACE OF (NJURY(Homa, farm, 201. (City or town) (Cou | nty) (State) |
| Hour a.m. While Not While | ory, street, office bidg., atc.) | |
| | ome Salisbury Vico | |
| 21. I certify that I took charge of the remains described above, he | | and in my opinion |
| death resulted from Natural causes . Accident x, St | picide, Homicide, Undetermined manner | |
| ACTUAL & | CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER | 22. DATE SIGNED |
| SIGNATURE | M D. ASSISTANT MEDICAL EXAMINER | |

2-10-66

REGISTRAR'S SIGNATURE

(Stafe)

Cannot be matched with birth certificate. .

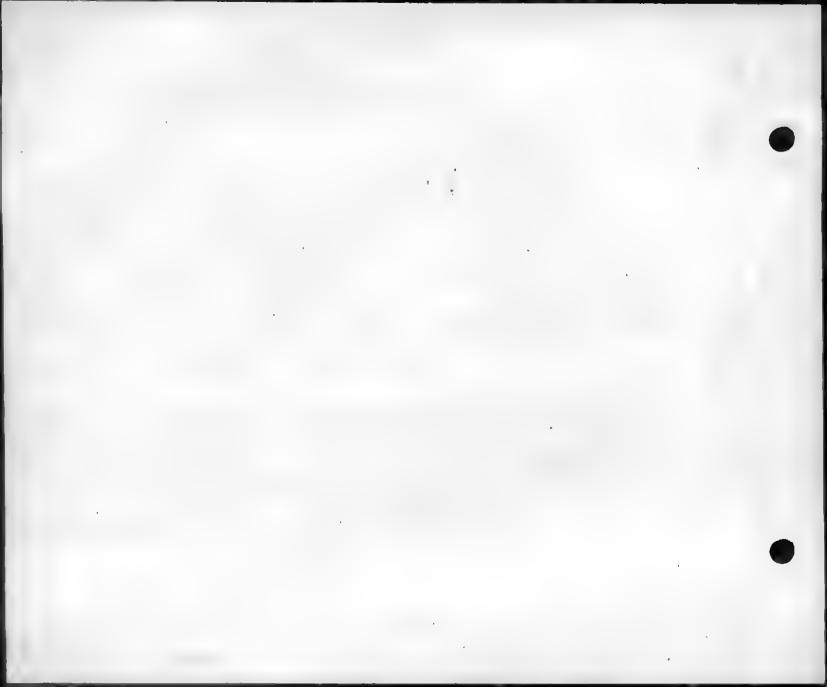
Entire family perished in fine Contacted

Pensonsula General Hospital, this birth

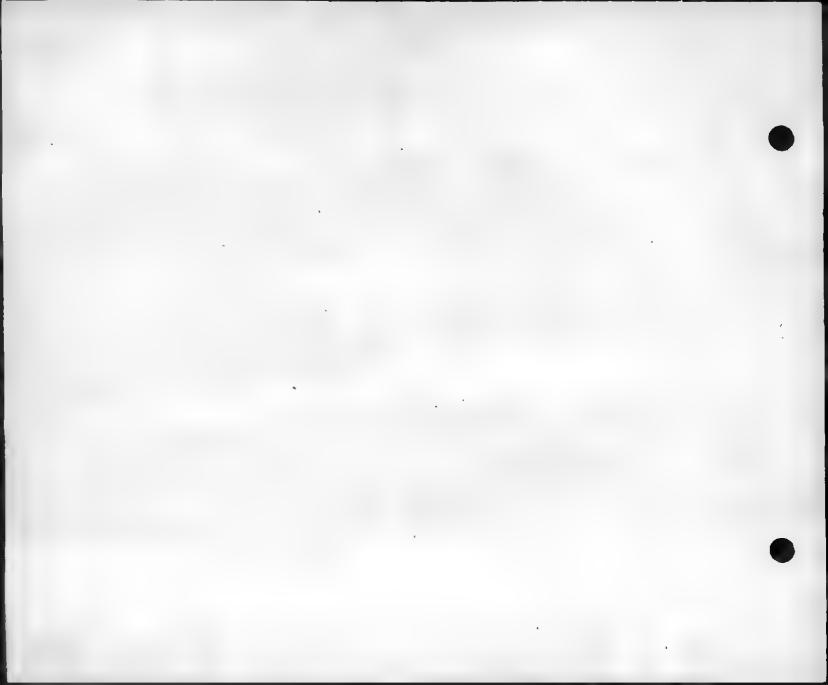
ded not occur there.

3/16/66-Mg.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND 35 CERTIFICATE OF DEATH destar مه نالا ت hours after death USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF OEATH a. COUNTY b. COUNTY 0 e by the MARYLANO C 0 m100 ithin 72 hours aft C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b Write RURAL and give nearest town) 00 0 completely filled in IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS ON A FARM? NOV YES NAME OF DECEASED executed within Middle DATE Month Last 4. Day Year remove car DEATH FEBRU 19 (Type or print) 0 31 AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS. DATE OF BIRTH 9. 5. SEX 6. COLOR OR RACE 7. MARRIED TO NEVER MARRIED iast birthday) | Months | Hours Days lease remov and in any and DIVORCED the attending physician are permit. Then please restion, or removal, and in a 10b. KIND OF BUSINESS OR INDUSTRY 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? certificate be soline tory Ke FATHER'S NAME MOTHER'S MAIDEN 15. WAS DECEASED EVER IN U.S. ARMED FORCES? a 2 Address 16. SOCIAL SECURITY NO. INFORMANT 17. (Yes, no, op unkown) [(If yes give war or dates of service) s been signed by the atters the burial-transit permits for to burial, cremation, o Y.Can ess INTERVAL BETWEEN CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). The law requires that the ONSET AND DEATH PART I. DEATH WAS CAUSED BY: O HOSPITAL OR ATTENDING FORESTIME TO Attending physician. Page 4 may be retained by the hospital or attending physician. IMMEDIATE CAUSE DUE TO Conditions. If any, which (b) gave rise to immediate DUE TO cause (a), stating prior underlying cause last, After this certificate has do be detached for use as state Dept. of Health prio (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO IF YES [PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING [DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part 1 or Part 11 of Item 18.) OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d. INJURY OCCURRED 120e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Hour a.m. While Not While at work at work 19 p.m. J FUNERAL DIRECTOR: Affi director, page 3 should b should be filed with the St 21. I certify that (I) (this hospital) attended the deceased from 19 that (I) (we) last and that death occurred at 9 M. from the causes and on the date stated above. saw the deceased alive on DATE SIGNED SIGNATURE 22b. 22a. STAFF ATTENOING DIRECTOR M.D. PHYSICIAN'S 22d. ADDRESS 22c. director, p NAME (Type) (State) 23c NAME OF CEMETERY OR CREMATORY 23d JLOCATION (City, town or sounty) 23a, BURIAL, CREMATION, 23b., DATE THEREOF REMOVAL (Specify) 2 Md rince 12121 MOYIS 22 FUNERAL DIRECT REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 15M 4-64



MARYLAND STATE DEPARTMENT OF HEALTH



funeral and 2 death, ve carbon papers. Pages 1 event, within 72 hours after Pages completely filled in TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and condinector, page 3 should be detached for use as the burial-transit permit. Then please demove should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any events.

24 haurs after death.

The law requires that the leath sertificate se executes within O HOSPITAL OR ATTENDING PHYSICIAN. The law requirem that the Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence a. COUNTY Accomac MARYLANO b. CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C LENGTH OF STAY IN 16 65 Walleps Island d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) K-11 NAME OF Middle DATE Month Last DECEASED OF DEATH CHESTER (Type or print) 6. COLOR OR RACE OATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 7. MARRIEO NEVER MARRIEO last birthday) Months Days WIOOWEO [OIVORCEO [10a. USUAL OCCUPATION (Give kind of workdone during most of working life, eyen if retired)

Arro-Space rechance 12, CITIZEN OF WHAT 11, BIRTHPLACE (County & State, or foreign country) Mulberry, Kansas 13. FATHER'S NAME 14. MOTHER'S MAJOEN NAME Unk' Lester Rowland 15. WAS OEGEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ((If yes give war or dates of service) Mrs.Ruth Wallops 16. SOCIAL SECURITY NO. E. Rowland (Wife)
Island, Virgini k-11 N.A.S.A. Umk INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] ONSET AND OEATH PART I. DEATH WAS CAUSED BY: Zr, much IMMEDIATE CAUSE (a) DUE TO (b).

e. IS RESIDENCE ON A FARM?

(State)

NO X

Conditions, if any, which gave rise to immediate **OUE TO** cause (a), stating the underlying cause last. CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO CHATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMEO? YES X NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of Item 18.) MEDICAL 20c. TIME OF INJURY Month, Oay, Year 20d. INJURY OCCURREO | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (State) Hour a.m. While Not While at work at work 21. I certify that (I) (this hospital) attended the deceased from and that death occurred at PM, from the causes and on the date stated above. saw the deceased alive on. DATE SIGNED 22a. SIGNATURE 22b. M.D. DIRECTOR

23c. NAME OF CEMETERY OR CREMATORY

1966 Hopkington Cemetery

SALISBURY, MARYLAND

ADDRESS

LOCATION (City, town or county)

25b. REGISTRAR'S SIGNATURE

Ashaway.

25a. REC'O BY REGISTRAR

VR A15 (4) 15M 4-64

PHYSICIAN'S

BURIAL, CREMATION,

24. FUNERAL OIRECTOR

oseph

COMPANY

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral should 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before edmission COUNTY b. COUNTY 22 NICOMICO MARYLAND b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If guiside corporate limits, write RURAL and give nearest lown) write RURAL and give nearest town) ElmAR d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) . IS RESIDENCE d STREET ADDRESS ON A FARM? YES NO completely 3. NAME OF DATE Middle Month DECEMBED (Type or print) DEATH Matilda Seward AGE (In yours IF UNDER 1 YEAR 5. SEX DATE OF BIRTH IF UNDER 24 HRS. 7. MARRIED W NEVER MARRIED and last birthday) WIDOWED DIVORCED physicia■ 10a. USUAL OCCUPATION (Give kind of work 10b KIND OF BUSINESS OR INDUSTRY BIRTHPLACE (County & State, or fore an country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired] Maryland Housewi fe None USA 13. FATHER'S NAME 1.14. MOTHER'S MAIDEN NAME Thomas Reed Elizabeth Quillen ă 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT (Yes, no. or unknown) | [[fyes give were rdates of service] Walter Seward Delmar. Maryland 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c)] INTERVAL BÉTWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: CARDIAC IMMEDIATE CAUSE (e) DUE TO arteroschoote Heart Dis. Conditions, if any, which gave rise to immediate cause DUE TO (a), steting the underlying cause last. PART II, OTHER'S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART III) 19. WAS AUTOPSY PERFORMED? NO 20a ACCIDENT WAS UNDERLYING 20b, DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Pert I or Pert I of Item 18) OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home farm. 20f. (City or town) (County) Month, Day, Year fectory, street, office bldg., etc.) While Not While Hour a.m. et work et work 19. 6 and that death occurred at 3 A.M., from the causes and on the date stated above 22a SIGNATURE STAFF SIGNED ATTENDING PHYS. DIRECTOR PHYS. 22d. ADDRESS 22c, PHYSICIAN'S NAME [Type] Grove Ernest 23d. LOCATION (City, lown or county) 23e. BURIAL, CREMATION OF CEMETERY OR CREMATORY REMOVAL (Specify) Templeville Templeville, Maryland Burie EB 28 1966 Cleanles Cus 24. FUNERAL DIRECTOR'S SIGNATURE VR A15 [4] 15M 7-62



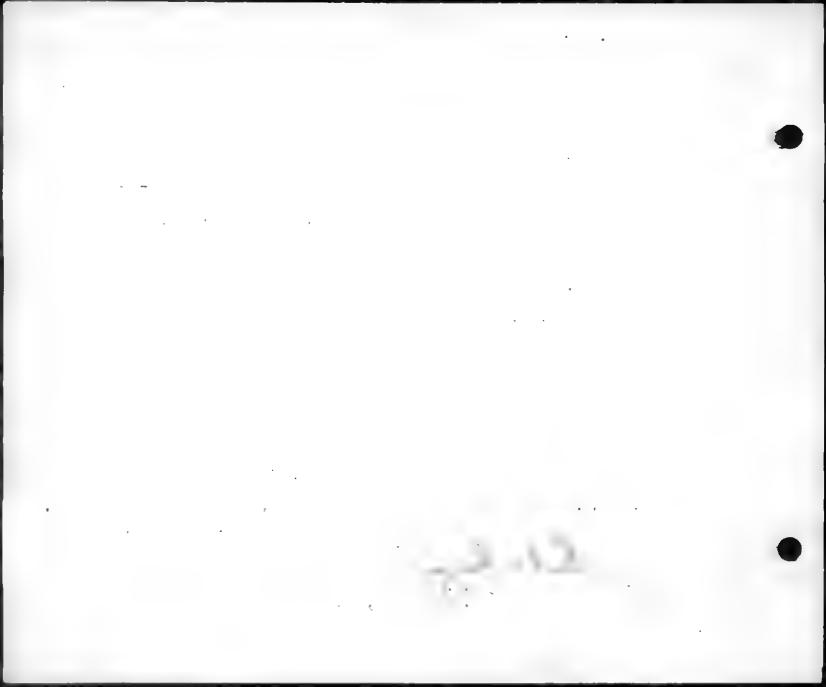
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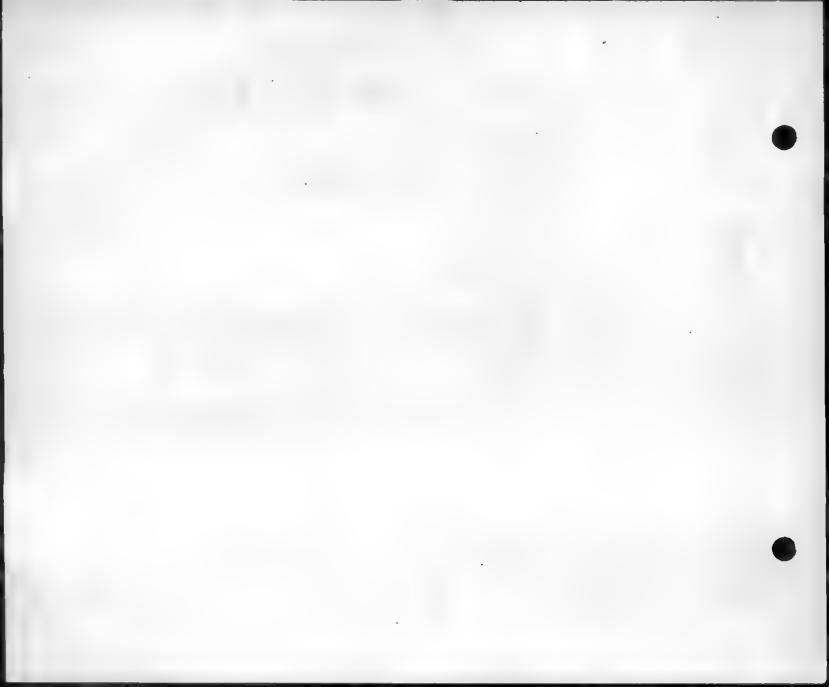
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission PLACE OF DEATH o COUNTY Maryland Wicomico Page Worcester c LENGTH OF STAY IN 16 c. C.TY OR TOWN (If outside corporate imits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporate mits, Snow Hill d NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS B IS RESIDENCE ON A FARM? farm haurs Peninsula General Hospital YES NO d te 8. Give Pages This certificate should be executed within 24 haurs after death 3. NAME OF Midd e Lost 4 DATE First Month OF DECEASED Shockley 2-19-66 Avery (Type or print) DEATH AGE (n years IF UNDER 1 YEAR F UNDER 24 HRS S SEX 6 COLOR OR RACE 8 DATE OF BRITH 7 MARR ED NEVER MARRIED Hours Nov. 18, 1906 WIDOWED DIVORCED event 100 LSLAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 B RTHPLACE (Stote or foreign country) 12 CITIZEN OF WHAT during most of working life, even if ret red)
Storekeeper Seafood COUNTRY? pages I Snow Hill, Maryland USA14 MOTHER'S MAIDEN NAME 3 FATHER'S NAME George C. Shockley Laura G. Hearne IS WAS DECEASED EVER NOS ARMED FORCES? 17 INFORMANT ---6 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dotes of service) remaval, Josephine Davis. Salisbury. 214164820 INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) PART I, DEATH WAS CAUSED BY: Crushed chest Б IMMED ATE CAUSE (0) writing the ward burial, cremation, DUE TO Canditions, if only, which gove rise to immediate couse (a), DUE TO stating the underlying couse 19 WAS AUTOPS PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) PERFORMED? NO 0 200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port or Port 1 of item 18) 6 3 should PRIMARY OF CONTR BUTING CAUSE OF AATH ď Passenger in car involved in collision with another car dgent, 20e PLACE OF INJURY (Home, form 20f (City or town) 20c TIME OF NILRY Month, Doy, Year Rt 113 at Rt. Not While of work 2-19+66 Berlin Worcester of work its designated 21. I certify that I taak charge of the remains described above, held an Autopsy Inspection 了 Induity XI. and in my opinion funeral director. death resulted frame? Natural couses Accident Su cide Undetermined manner Hamicide CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASS STANT MEDICAL EXAMINER SIGNATURE 2-21-66 Earl L. Royer, DEPUTY MEDICAL EXAMINER Health NAME (Type) Address (Street, city, town, or county) 23b DATE THEREOF Galisbury Md 230 BURIAL CREMATION. 23d LOCATION (City or Town) (County) 9 2/22/66 Mt. Zion Cemetery Snow larvland 24. FUNERAL DIRECTOR 250 REC D BY REGISTRAR

Snow Hill, Maryland

VR A15ME (5%)



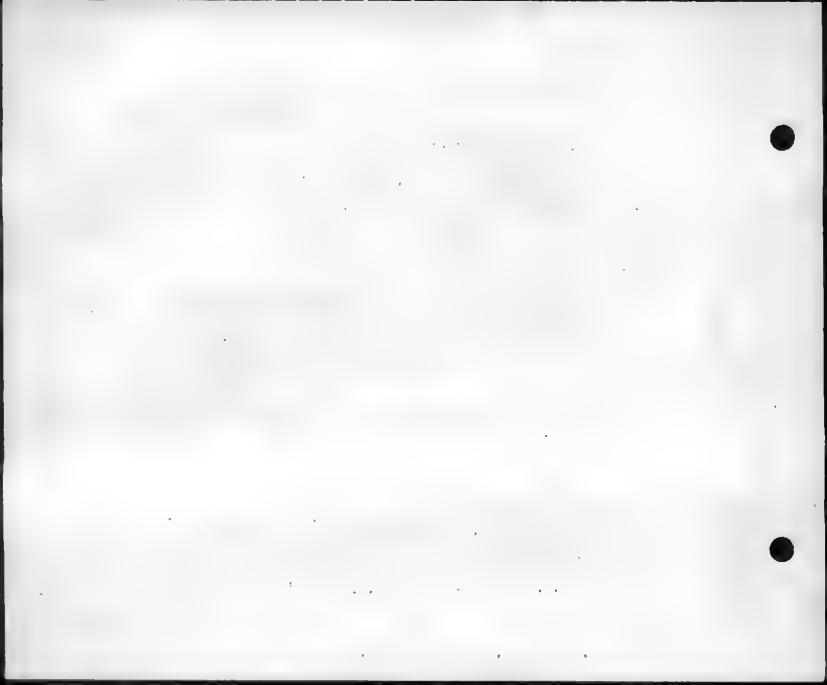
| _ 1 / | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND |
|--|--|
| 4 700 | 03033 CERTIFICATE OF DEATH |
| hours after death. d in by the funeral rs. Pages 1 and 2 2 hours after death. | 1. PLACE DE DEATH 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission a. COUNTY 3. STATE b. COUNTY |
| after the after | b. CIDY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town |
| in by Page | Virite RURAL and give nearest town) |
| filled in papers. Inin 72 hour | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENC ON A FARM? |
| ithin 24 hours tely filled in by son papers. Pag within 72 hours | 3. NAME DF DECEASED First Middle Last 4. DATE Month Day Year |
| executed within and completely from property from property from property from property within | (Type or print) // ILL IAM G SINNAMON DEATH PERMAR, 9 25 1966 |
| ecute nd co nove ny ev | 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 19. AGE (In years FUNDER 1 YEAR FUNDER 24 HR One 19. AGE (In years FUNDER 1 YEAR FUNDER 24 HR Iast birthday) Months Days Hours Min |
| De ex | 10a. USUAL OCCUPATION (Give kind of workdone 10b. KIND OF BUSINESS OR during most of worklog life, even if retired) INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? |
| nysterian | TRIAL WAGISTRATE COUNTY PHILADELPHIA A - W, S. A. |
| certifica Iding ph Then remova | WILLIAM SINNAMON VIRGINIA SMITH |
| ath certific attending primit. Then n, or remov | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service) |
| e death | 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] |
| that the deal sician. Sician. gned by tima at intransit pertial, cremation, lai, cremation. | PART I. DEATH WAS CAUSED BY: IMMEDIATE GAUSE (a) Center or was and co. I PART I. DEATH WAS CAUSED BY: IMMEDIATE GAUSE (a) Center or was a constant or was |
| fres that the physician. I signed by burial-transi burial, crem | Conditions, if any, which \ |
| requires ding phy been si the bur or to bur | gave rise to immediate (b) cause (a), stating the DUE TO |
| law requires that tatending physician, has been signed be as the burial-tranth prior to burial, cre | underlying cause last. (c) |
| To start | PERFORMED? YES NO |
| ICIAN: The lospital or a certificate for use the for use of Health | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED (YES NO PERFORMED) YES NO PERFORMED (YES NO PERFORMED) YES NO PERFORMED (YES NO PERFORMED) OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |
| OR ATTENDING PHYSICIAN: be retained by the hospital JIRECTOR: After this certific ge 3 should be detached for ed with the State Dept. of H | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Hour a.m. Description |
| TTENDIN etained I TOR: Aff should b | 21. I certify that (I) (this hospital) attended the deceased from 2/2/, 19.45, to 2727, 19.65, that (I) (we) la |
| ECTO 3 sho | saw tro deceased alive/on |
| AL OR lay be page filed | ACE STAFF ALCONOMICS M.D. ATTENDING MED. STAFF DIRECTOR PHYS. D 22c. PHYSICIAN'S 22d. ADDRESS |
| SPITA 14 m 14 m 14 ctor, 1 1d be | NAME (Type) |
| TO HOSPITAL OR AITEN Page 4 may be retaine TO FUNERAL DIRECTOR: director, page 3 should should be filed with the | 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OF CREMATORY 23d. LOCATION (City, town or county) (State) |
| 0 | 2 27 66 S WAREST DEMORIAL SET OF REGISTRAR'S SIGNATURE |
| VR A15 (4) 15M 4-64 | Anna A. Burbage Bulin Md. md AR 3 1966 g anles Judge |



VR A15 (4) 15M 4-64 1.

| | ARCH AND RECORDS | PARTMENT OF HEALTH , 301 W. PRESTON STREET, BALTIMORE 1, MA E OF DEATH | RYLAND 2025 |
|--|-------------------------------|---|-------------------------------|
| PLACE OF DEATH a. COUNTY Wicomico | MARYLAND | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Resi a. STATE b. COUNTY Some: | rset , |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and Princess Anne, Maryland | d give nearest town) |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in h | ospital, give street address) | d. STREET AOORESS | e. IS RESIDENCE ON A FARM? |

| 1 | | | Wicomic | 0 | | MARYLA | IND | 4, 517 | Mary | land | | 21 00011 | Some | rse | t | |
|----|---------------|--|--------------------------------------|----------------------------|-----------------|----------------------|---|---|-------------|------------------|------------|----------------------------|---------------|-------------------|-----------|----------|
| | b. | CITY OR TOW write RURAL | N (If outside o | orporate lin | ilts, c. Li | ENGTH OF STAY I | N 15 | c. CITY OR | TOWN (If o | outside co | orporate | llmits, writ | e RURAL | and glv | e neares | t town) |
| 1 | | Salisb | | est (OMII) | 7 | days | | 1 | rince | ss Ar | me. | Maryl | and | | 2 | |
| 1 | d. | | | TITUTION (IF | | l, give street add | iress) | d. STREET | | | | | 1,4 0 0 to 1. | е. | IS RES | IDENCE |
| | | Deer | s Head | State | Hospita | 1 | | | | | | | | | | NO . |
| - | | AME OF ECEASEO | - | First | | Middle | | Last | | 4. DATE | | Month | | Day | Yea | ir |
| 1 | | ype or print) | | Thomas | , | В. | | Smi | th | DEAT | TH | Februa | ry | 6 | 19 | 66 |
| ľ | 5. SE | EX | 6. COLOR OR | RACE 7. N | ARRIED N | EVER MARRIED | 8 | . DATE OF | BIRTH | ć | AGE | (In years I birthday) | FUNDER 1 | | | |
| Y | | [ale | Colore | | 100WED | DIVORCEO | | 3/11/ | | | 67 | yrs. | | Days | Hours | Min. |
| Л | 10a. U: | SUAL OCCUPAT most of work | ION (Give kind : Ing life, even 1 | of work done f retired) | TRUDING | F BUSINESS OR | | | | unty & Stat | te, or for | reign country) | | TIZEN (Untry: | F WHAT | |
| | | Labor | | , | Saw Mi | | | Mary | land | | | | US | 3 A | | |
| | 13. F | ATHER'S NAM | E | | | | | 14. MOTH | ER'S MAIDE | EN NAME | | | | | | |
| 1 | B | essie | Smith | | | | | | ? | | | | | | | |
| İ | 15. W | AS DECEASEO | VER IN U.S. AR | MEO FORCES | ? 16. SOCIA | AL SECURITY NO. | 17. | INFORMANT | | | | Addres | S | | | |
| - | (165) 8 | nu, or carecurity | / 11 Act Rive were | A CHARCES OI SHALLS | LC) | | Lo | vie D | ashie | eld F | rir | ncess | Anne | e.Mo | 1 | |
| | 18 | B. CAUSE OF | DEATH [Enter | only one cau | se per line for | r (a), (b), and (c). | | | | | | | | INTER | RVAL BE | TWEEN |
| - | | DAGT 1 DEATH WAS CAUSED DV. Co. 3 A 9 9 94 | | | | | | | | | | T ANO I | | | | |
| - | | 1/2 = 1 | | | | | | | | | | | | | | |
| | C | Carditions | | | | | | | | | | | | | | |
| -1 | g | ave rise to | Immediate (| (b)_ DUE TO | | | | | | | | uffici | | | | |
| | | ause (a), si nderlying caus | | | | | | | | | | | | | | |
| | | | | (c) ONDITIONS C | ONTRIBUTING | TO CEATH BUT NO | TRELA | TED TO THE T | ERMINAL D | ISEASE CO | NDITIO | N GIVEN IN P | ART 1(a) | 119. | WAS AL | TOPSY |
| | CERTIFICATION | CA | of pro | state | | | | | | | | | | YE | PERFOR | NO MEDY |
| | E 2 | Oa. ACCIDENT | WAS UNDERLY | ING [| 20b. DESCR | IBE HOW INJURY | OCCU | RRED. (Ente | r nature of | injury in | Part I | or Part II of | Item 18. |) | | |
| | | R CONTRIBUTI | NG III CAUSE FIFY MEDICAL | OF DEATH EXAMINER) | | | | | | | | | | | | |
| | EDICAL | Oc. TIME OF | | , Day, Year | 20d. INJURY | | | CE OF INJUR | | | (City | or town) | (Cou | nty) | (| State) |
| | 9 | Hour a.r | | 19 | While At work | ot While at work | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | | | | |
| | | 21. certif | v that (I) (th | is hospital) | attended th | e deceased fro | m | Jan. 2 | 7 , 19 | .66, to | 0 F | eb. 6 | , 19 6 | 6, th | at (I) (v | ve) last |
| | | saw the de | ceased office | one F | eb. 6 | 19 66 , an | d that | death occ | urred at 1 | <u>la m, 1</u> | from th | he causes a | | | | above. |
| - | 2 | 2a. SIGNATUI | | | 1/1/ | | | ATTEMBI | NO 5 | 4CD | 6 | TAFF - | 22b. D/ | | NEO | |
| | | 11 | 11/1/2 | | or of | | M.D | | | MED. DIRECTOR | P | HYS. | 2/7 | /66 | | |
| | 2 | 2c. PHYSICIA | | | | | - | 22d. A | | | | | | | | |
| | _ * | | C.F | .Gutle | rrez-Ga | rrido, M | ·n• | Deer | r's Me | | | tal; S | | | | * -= = |
| | 23a. | BURIAL, CREM REMOVAL (Spe | alful (| DATE THER | | . NAME OF CEN | METERY | OR CREMAT | ORY | 23d. | LOCATI | ON (City, to | wn or cou | inty) | (S | tate) |
| | Bu | rial | 4/ | II/66 | | st Paul | | | | Mt | | rnon | Mary | y la | nd | |
| | | FUNERAL DIRE | | | | ADDRESS | | | | D BY REC | | 25b. RE | | - 0 | | |
| 2 | Wi | Lliam | H.Jame | s Jr. | Prince | ess Ann | e,M | a | DATEEB | 10 | 196 | 6 / | 1 | v Ja | edge | b |



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The faw requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

| | MARYLAND STATE DEPARTMENT OF HEALTH | |
|-----------------|---|--------------------|
| DIVISION OF | STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, | , MARYLAND |
| 02040 | CERTIFICATE OF DEATH | 1130% |
| DI ACC DE DESTI | II O HOUSE PREIDENCE (Miles Jacons Fred & Institution | a Carldonna before |

| | DIVISION OF STATISTICAL RESEARCH AND RECORDS | | MARYLAND | | | | | | |
|---------------|---|--|--|--|--|--|--|--|--|
| | CERTIFICAT | E OF DEATH | 35026 | | | | | | |
| 1. | PLACE OF DEATH a. COUNTY | 2. USUAL RESIDENCE (Where deceased lived, If Institution: | Residence before admission) | | | | | | |
| | WICOMICO MARYLAND | a. STATE N.J. b. COUNTY | uster / | | | | | | |
| - | b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) | c. CITY OR TOWN (If outside corporate limits, write RUR) | Al. and give nearest town) | | | | | | |
| | Salisbury | Wemonah | 61 | | | | | | |
| | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | e. IS RESIDENCE ON A FARM? | | | | | | |
| 1 | Peninsula General Hospital | | YES NO X | | | | | | |
| 3. | NAME OF First Middle | Last 4. DATE Month | Day Year | | | | | | |
| | (Type or print) MARGUERITE C. | Suau DEATH February | 1966 | | | | | | |
| 5. | SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | 8. DATE OF BIRTH 9. AGE (In years IF UNDE last birthday) Months | R 1 YEAR IF UNDER 24 HRS. | | | | | | |
| 1 | emale white WIDOWED OIVORCED | Dec. 22/1893 72 yrs. 1 | 9 | | | | | | |
| 1 dt | a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR Iring most of working life, even if retired) INDUSTRY | | CITIZEN OF WHAT COUNTRY? | | | | | | |
| 1 | None | New York City N.Y. | USA | | | | | | |
| 1 | 3. FATHER'S NAME | 14. MOTHER'S MAIOEN NAME | | | | | | | |
| | William McDonald | Elizabeth Brady | | | | | | | |
| 10 | 5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. Mx. or unkown) (If yes give war or dates of service) | HEGEMANT Suan (Hus pand) 325 I | Primeeton | | | | | | |
| - | NG | Ave. Salisbury Maryland | PI=2=3892_ | | | | | | |
| | 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN | | | | | | |
| | PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chydiac o | ireld | instant | | | | | | |
| | DUE TO DUE TO | | | | | | | | |
| | Conditions, if any, which gave rise to immediate (b) reval for | one week | | | | | | | |
| | cause (a), stating the DUE TO | | | | | | | | |
| 1 | underlying cause last. (c) | | NAME AND ADDRESS OF THE PARTY O | | | | | | |
| O.L. | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT REL | | - PERFURIMENT | | | | | | |
| , [S | Cerebral Vascu | lar occidents (Thrombosi | | | | | | | |
| CERTIFICATION | 20a. ACCIDENT WAS UNDERLYING COR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | URREO. (Enter nature of injury in Part I or Part II of Item : | 18.) | | | | | | |
| | | | (21-1-) | | | | | | |
| MEDICAL | 20c. TIME OF INJURY Month, Cay, Year 20d. INJURY OCCURRED 20e. PL fact While Not While | ACE OF INJURY (Home, farm, 20f. (City or town) (C tory, street, office bidg., etc.) | (State) | | | | | | |
| 3 | p.m. 19 at work at work | | | | | | | | |
| | 21. I certify that (I) (this hospital) attended the deceased from | 1/2-5/66, 19 to 2/1/66, 19 | | | | | | | |
| П | | at death occurred at 4.50 M, from the causes and on | DATE SIGNED | | | | | | |
| | 22a. SIGNATURE | ATTENDING TO MED. STAFF | / / | | | | | | |
| | 22c. PHYSICIAN'S M. M. | O, PHYS. DIRECTOR PHYS. | 1/66 | | | | | | |
| | NAME (Type) | | ury, Md. | | | | | | |
| 2 | a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETER | | | | | | | | |
| | "Burial" Feb. 4/1966 Wiconice Me | | | | | | | | |
| 2 | 4. FUNERAL DIRECTOR ADDRESS | 25a. REC'O BY REGISTRAR 25b., REGISTRA | AR'S, SIGNATURE | | | | | | |
| I | HOLLOWAY & COMPANY SALISBURY, MARY | LAND FAFEB 7 1966 Jelianle | Judge | | | | | | |
| - | | | | | | | | | |

VR A15 (4) 15M 4-64



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 02074

| USUNE CERTIFICAT | E UF DEATH | 1,4,114,13 |
|--|--|----------------------------|
| 1 DIAGE DE GERTU | 2. USUAL RESIDENCE (Where deceased lived, if institution: | Residence before admission |
| a. COUNTY Wicomico | a. STATE Maryland b. COUNTY W: | icomico |
| b. CITY DR TOWN (if outside corporate limits in LENCTH OF STAY IN 15 | c. CITY OR TOWN (If outside corporate limits, write RURAL | and give nearest town |
| Salisbury 2/7/66 | Fruitland (P.O.H | 3.#443) |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | d. STREET ADDRESS | e. IS RESIDENC |
| Pen.Gen.Hospital | Hayward Ave. | YES NO X |
| 3. NAME OF First Middle DECEASED (Type or print) KATHERINE (KATIE) ANNA | A TOMLIN DEATH FEB. 14 | Day Year 1966 |
| 5 CEV (C DOING OD DAOT) | 8. DATE OF BIRTH 19. AGE (In years I F INDER | 1000 |
| The state of the s | Nov.13/1888 77 yrs. Months | Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done 1Db. KIND OF BUSINESS OR | 11. BIRTHPLACE (County & State, or foreign country) 12. C | ITIZEN OF WHAT |
| during most of working life, even if retired) 100186 W116 NONE | Baltimore, Maryland U | OUNTRY? |
| 13. FATHER'S NAME | 14. MDTHER'S MAIDEN NAME | |
| Charlie Cathell | Lena Bachman | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORGES? (Yes, no, or unkown) (if yes give war or dates of service) 16. SDCIAL SECURITY ND. 17. MI | informant C. Tomlin (Musband) | |
| 13-7-2-7-17 | (Same as #2 above) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | INTERVAL BETWEEN |
| PART I. DEATH WAS CAUSED BY: Curling Mediate Cause (a) | implusation. | 2.66 |
| " DUE TO | - 11. = | Alava |
| Conditions, If any, which (b) Regeneration | Aleast Disease | Tucca |
| gave rise to immediate (cause (a), stating the DUE TO | | |
| underlying cause last. (c) | | |
| PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELIED TO BE A COLOR OF THE PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DESCRIBE HOW INJURY OCCUPANTIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | ATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | 19. WAS AUTDPSY PERFORMED? |
| 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCU | URRED. (Enter nature of Injury in Part I or Part II of Item 18 | |
| G DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | |
| 3 20c. TIME OF NURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLA | | unty) (State) |
| 20c. TIME OF NJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLA Hour a.m. p.m. 19 While at work at work at work | ory, street, office bldg., etc.) | |
| 21. I certify that (I) (this hospital) attended the deceased from | 1950 to - 1/199 | that (I) (we) las |
| | t death occurred at M. from the causes and on t | |
| 22a. SIGNATURE | | TATE SIGNED |
| Hellenun Frag M.E | D. PHYS. MED. STAFF DIRECTOR PHYS. Feb | 17 /1966 |
| 22c, PHYSICIAN'S NAME (Type) | 22d. ADDRESS | |
| NAM Dr. William D. Gray | Canden Ave, Salisbury, Mar | yland |
| 23a. BURIAL, CREMATION, 23b. DATE THEREDF 23c. NAME OF CEMETER'S REMOVAL (Specify) | Y OR CREMATORY 23d. LOCATION (City, town or co | unty) (State) |
| Burial Web. 17/1966 Wicomico Me | emorial Park Salisbury, Ma | |
| 24. FUNERAL DIRECTOR ADDRESS | 25a. REG'D BY REGISTRAR 25b. REGISTRAR | - |
| HOLLOWAY & COMPANY SALISBURY MARY | LAND DAFEEB 21 1966 Pliant | es Judge |

1966

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please femaly carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and itheny event, within 72 hours after death. TO BORNITAL OR ATTENDING PHYS IM. The law requires that the death contincate be executed within 24 hours after deuth. Page 4 may be retained by the hospital or attending physician.

1/65 A15

1. . .

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH ب ته ته after death. and 2 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY b. COUNTY Wicomico Wicomico Maryland rbon papers. Pages 1, within 72 hours after MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b hours Salisbury 22 Davs Salisbury d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS ON A FARM? YES NO Deer's Head State Hospital, Salisbury, Md. S. Division within completely carbon DATE Month Day Year DECEASED and complet remove carb 19 66 DEATH (Type or print) Townsend Feb. AGE (In years | IF UNDER 1 YEAR HE UNDER 24 HRS. executed 5. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 7. MARRIED A NEVER MARRIED last birthday) | Months | Days Hours White Male WIDOWED I DIVORCED 12. CITIZEN OF WHAT nding physician a Then please re removal, and in 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 10a, USUAL OCCUPATION (Give kind of work done ! COUNTRY? during most of working life, even if retired) INDUSTRY death certificate be RET. NURSERYMAN U.S.A OWNER MARYLAND 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME attending permit. Ther SHOCKLEY AMELTA TOWNSEND 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address has been signed by the attent as the burial-transit permit. prior to burial, cremation, or (Yes, no, or unkown) (If yes give war or dates of service) MRS. HUGH W. DAUM. CRETE. ILLINOIS INTERVAL BETWEEN 18. CAUSE DF BEATH [Enter only one cause per line for (a), (b), and (c),] The law requires that the ONSET AND DEATH PART I. DEATH WAS CAUSED BY: CA of the stomach with advanced metastasis Months the hospital or attending physician. IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to immediate **DUE TO** cause (a), stating the underlying cause last. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) for use Health p this certificate I detached for use te Dept. of Health PERFORMED? CERTIFICATI YES TX NO T 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) ATTENDING PHYSICIAN: (State) MEDICAL 20f. (City or town) (County) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Hour a.m. - Not While DIRECTOR: After age 3 should be o at work p.m. at work retained 66. to 19_66, that (f) (we) last 19 21. I certify that (I) (this hospital) attended the deceased from and that death occurred at 9:00M, from the causes and on the date stated above. <u> 19 66</u> saw the deceased alive on with 22b. DATE SIGNED 22a. SIGNATURE þ page : 2/23/66 M.D. DIRECTOR PHYS. шау TO FUNERAL PHYSIC ANS 22d. ADDRESS director, p should be f NAME (Type) Head State Hospital, Salisbury Gutierrez-Garrido, M.D., Deer's 23c. NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23a. WICOMICO MEM. PARK 26/1966 FUNERAL DIRECTOR ADDRESS REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR AIII (4) 1/65

MARYLAND STATE DEPARTMENT OF HEALTH



ADDRESS

City.Md.

Pocomoke

wayson

VR A15 (4)

PUNERAL DIRECTOR



VS A15ME(5) 5M 9/55 03044

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Real Dist. No.

| ^ 5 | * 7 | 11) | |
|-----|------|------|---|
| ş. | 8.47 | UJ | Î |

| | PLACE OF DEATH b. COUNTY | omi co | | MARYLA | Ne | O. STATE . | Dence (Marv) | | ed lived. If Institu | | rce befo | ore admi | ssion) |
|---------------|---|---|----------------------|---------------------------------------|------|-------------------------|--------------|------------------------|---|--------------|--------------|-----------|--------------------------|
| | | omico outside corporate limits, writ isbury | e RURAL | c. LENGTH OF STAY IN 7 Mons. | | c. CITY OR | | autide corp | parote limils, write | RURAL and | give ne | orest for | rn) |
| | . NAME OF HOSPITA | | | pital, give street address) | | d. STREET A | | dens | Apartmen | ts | | ON | SIDENCE A FARM? |
| | NAME OF DECEASED (Type or print) | RAYMOND Fir | Tal. | Middle KING | | Lost TRU | ITT | 4. DATE OF DEATH | Mont 2 | h | Day 22 | | 9 66 |
| 5. 9 | Male | 6. COLOR OR RACE | 7. MARRII WIDOWEI | ED MEVER MARRIED [| ~ | DATE OF BIRTH | Li. | | 9. AGE (In years lost burthday) 51 yrs. | Months C | YEAR Days | IF UNDI | Min. |
| 100 | | N (Give kind of work life, even if retired) | | Clerk | 1 - | Y 11. BIRTHPLA | | or foreign o | 7-1 | | EN OF | | COUNTRY? |
| 13. | FATHER'S NAME | | | | | 14. MOTHER'S | | | | | | | |
| | | K. Truitt | | | | May S | erman | 1 | | | | | |
| 15 (Yan | . ng. or unknown) | R IN U. S. ARMED FO (11 yes, give war or dates of W.W. II | service) | social security no. 11 L4-1.0-8458 | | s. R. K | ing T | ruitt | , Same | | | | |
| CERTIFICATION | 20g. EXTERNAL CAU | ote couse DUE TO Color SER SIGNIFICANT CON SE WAS 120 | DITIONS CO | DITRIBUTING TO DEATH B | | | | | | VEN IN PART | | PERFO | AUTOPSY RMED? NO P |
| MEDICAL CERT | PRIMARY OF CON CAUSE OF DEATH. 20c. TIME OF INJUR' Hour o. m. p. m. | TRIBUTING L | or 20d. White | NJURY OCCURRED 206. | PLAC | E OF INJURY (H | lome, farm | . i 20f. (City | | (Cour | nty) | | (Slote) |
| | | at I taak charge from: Natural | _ | emaine described of Accident | | e, held an ide [], H | | - | nspection Landetermined of | - L | 8 | and f | ind that |
| | ACTUAL | and L. | K | | | M.D. CHIEF M | EDICAL EX | AMINER 🗍 | | | | DATE S | IGNED |
| | NAME (Type) | | ~ | r | | | | AL EXAMINE EXAMINER | | 2 | ٦- ١ | .4- | u |
| 220 | BURIAL, CREMATION REMOVAL (Specify) | , 22b. DATE THEREC | >F | 22c. NAME OF CEMETERY | | | | | TION (City, town, | | | (Stote |) |
| 200 | Burial | 2-25-19 | 66 | Parsons Cem | ete | | A/ | | isbury, l | | | | |
| | funeral director: Hill Funer: | | alish | ury, Marylan | д | | | 8Y REGIST | RAR 24b. REGI | STRAR'S SIGI | NATUR | E | |
| l | | WI HOMO O | CALL DU | ary mary tark | | | SATE B | 40 1 | 2.25 | " + LART | in An | - 12 | |



| ì | *) | 13 | , | |
|---|-----|----|---|---|
| | £.3 | 17 | J | 2 |

| | 03045 | MEDICA | L EVAMINER 3 | CERTIFICA | IE OF | DEATH | Reg. Dist. No | . O ! ! ! ! ! | | |
|-------------------|---|---|-----------------------------|--|------------------------|-----------------------|--------------------|--|--|--|
| | PLACE OF DEATH | | | 2. USUAL RESIDENCE (V | | ed lived. If institut | tion: Residence be | fore admission) | | |
|)[| Wic | omico | MARYLAND | . STAT Maryla: | nd | b. COUNTY | Wicomi | 20 | | |
| | b. CITY OR TOWN (If and give nearest town) | outside corporate fimits, write RURAL | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lawn) | | | | | | |
| | | | 30 Yrs. | Salisb | ury | | • | 0 9 1 | | |
| | d. NAME OF HOSPITA | L OR INSTITUTION (If not in hos | pital, give street address) | d. STREET ADDRESS | | | | e, IS RESIDENCE | | |
| | Parsons RD., | | | Parson | s Rd., | | | YES NO 1 | | |
| | 3. NAME OF DECEASED (Type or print) | First MAE | Middle ELIZABETH | TURNER | 4. DATE OF DEATH | Manth 2 | 20 20 | Year 19 66 | | |
| | 5. SEX | DATE OF BIRTH | 9. AGE In years | | IF UNDER TYEAR | | | | | |
| | Female | Whate WIDOWE | DIVORCED 🔲 La | anuary 18,18 | 89 | 77 yrs. | Months Doys | Hours Min. | | |
| | 10a, USUAL OCCUPATIO during most of working | N (Give kind of work done 10b. K | IND OF BUSINESS OR INDUSTR | Y 11. BIRTHPLACE (Stote | or fareign o | ountry) | 12. CITIZEN O | F WHAT COUNTR | | |
| | House Wif | Maryland | | | U.S.A. | • | | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | | |
| | Stanford | | Elizabeth Ellen Nicholson | | | | | | | |
| | 15. WAS DECEASED EVE (Yes, no. or unknown) NO | R IN U. S. ARMED FORCES? 16. (If yes, give wor or delet of service) | | FORMANT S. Minnie C. | Gordy | Address , Salisbu | ury, Mr | yland | | |
| | PART I. DEATI | H (Enter only one cause per line of the WAS CAUSED BY: MMEDIATE CAUSE (a) | for to). (b), and (c).) | otic am | | | INTE | ET AND ONTH | | |
| | Conditions, If on |). | 0 | | 5 | yun | | | | |
| | (o), stating the u | | | | | | 6 | | | |
| | PART II, OTH | ER SIGNIFICANT CONDITIONS CO | NTRIBUTING TO DEATH BUT NO | | | | | 9. WAS AUTOPSY PERFORMED? YES NO | | |

PRIMARY | or CONTRIBUTING CAUSE OF DEATH. MEDICAL 20c. TIME OF INJURY Month, Day, Year a. m. p. m.

20d. INJURY OCCURRED Not while at work of work

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.

20f (City or fown) (County)

Undetermined cause

Salisbury, MAryland

(State)

21. I certify that I taak charge of the remains described above, held an Autapsy death resulted from: Natural causes

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

Homicide

DATE SIGNED

and find that

EXAMINER'S NAME (Type) Dr.

ACTUAL

SIGNATUE

Earl L. Royer 220. BURIAL CREMATION, 22b. DATE THEREOF REMOVAL (Specify) 2-23-1966

22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery

DEPUTY MEDICAL EXAMINER 22d. LOCATION (City, town, or county)

Inspection

(State)

2-21-1966

2-23-1966 23. FUNERAL DIRECTOR'S SIGNATURE

Hill Funeral Home

ADDRESS Salisbury, Maryland 24g REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Inquiry

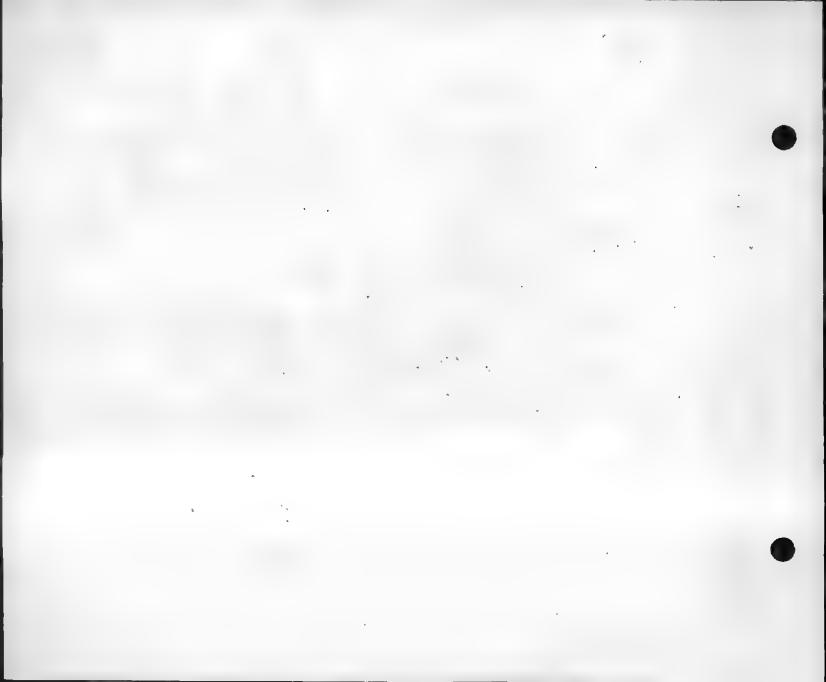
VS. ATSME(S) SM 9/SS

ar remayal

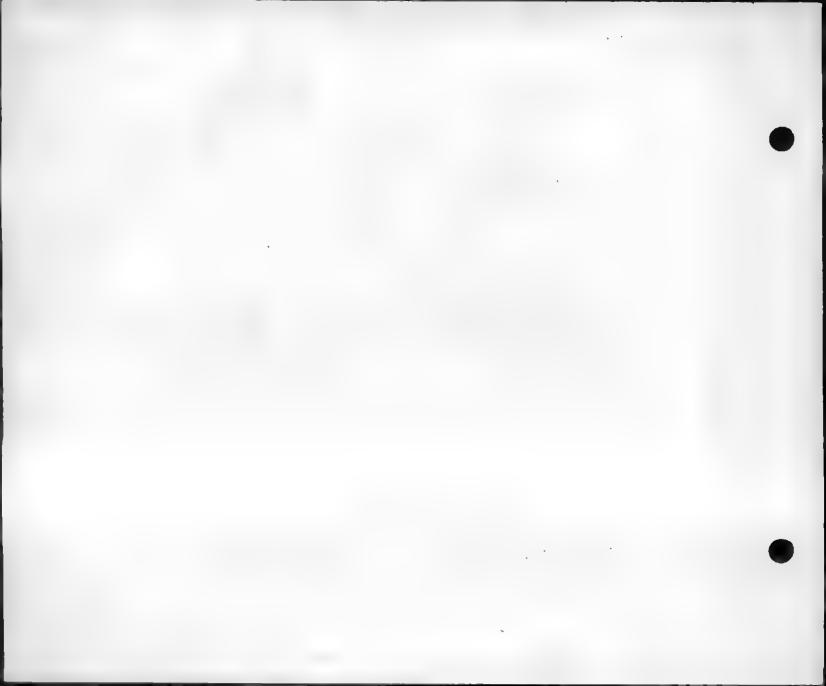
O DEPUTY MEDICAL



| | 1 | | DIVISION OF STATISTICAL RESE | | | HEALIH I STREET, BALTIMORE 1, | MARYLAND |
|--|--|---------------|--|-------------------------------|--|---|-----------------------------------|
| 4 .= | 10 Z | 3 | 03046 | CERTIFICATI | E OF DEATH | , | 113033 |
| 24 hours after death | by the funeral Pages 17 and 2 irs after death. | | PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE | (Where deceased lived, If institution: | Residence before admission) |
| fer | te y | | Wich mici | MARYLAND | maryla | nd W1 | Comice |
| उ | by t Page Irs a | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If o | utside corporate limits, write RURA | (L and give nearest town) |
| hou | d in rs. 2 hou | | d. NAME OF HOSPITAL OR INSTITUTION (if not in h | ospital, give street address) | d. STREET ADDRESS | 4-9 | B. IS RESIDENCE |
| | | 1 | Prinsula Hunara | -4 | 821 Rose, | 15 57 | YES NOV |
| 排 | etely bon witt | 3. | NAME OF FIRST | Middle | Last | 4. DATE Month OF DEATH F G F G G F L | Day Year |
| ed s | event, | 5. | SEX 6. COLOR DR RACE 7. MARRIED | Wat Ker | ر کے ا B. DATE DF BIRTH | 19 AGE (In years LIFTING | 9 1926 RIYEAR FUNDER 24 HRS. |
| ecut | | 1 | make WIDOWED | DIVORCED / | Max 18 18 | 9) last birthday) Months | Days Hours Min. |
| 9 | a a a a a a a a a a a a a a a a a a a | 10. | a. USUAL DCCL PATION (Give kind of work done 10b. K Ing most of working life, eyen if retired) 11b. K | IND OF BUSINESS OR | 11. BIRTHPYACE (Con | inty & State, or foreign country) 12. | CITIZEN OF WHAT |
| te b | ysici pleas , a∎c | 1 | post Dullder | | Somerse | tio. Md | 263 |
| tifica | g ph | 13 | PATHER'S NAME - 11/2/40 | | TYANCE | a = M, 10.5 | |
| Sel | attending physician ermit. Then please r on, or removal, and in | | . WAS DECEASED EVER IN U.S. ARMED FORCES? 16. | SDCIAL SECURITY NO. 17. | INFORMANT | Address Lo. | eers JE |
| seath | e att | | o, io, o unionity (1) yes give war of faces of service) | Mass | Jennie W. | alker Salis | bury |
| 9 | d by the attenctransit permit. | | 18. CAUSE OF DEATH [Enter only one cause per i | ine for (a), (b), and (c). | regres 1 | Charles. | ONSET AND DEATH |
| Tat. | ician. ned by th I-transit II, cremal | | IMMEDIATE CAUSE (a) | the buff + | aline of | + Halinin | , |
| les S | g physician. In signed by the burial-transit of burial-transit orems | | Conditions, if any, which } (b) | proting / | Leut 5 | Failur - | С |
| The law requires that the death certificate be executed within | Page 4 may be retained by the hospital or attending physician. O FUNERAL DIRECTOR: After this certificate has been signed by director, page 3 should be detached for use as the burial-transhould be filed with the State Dept. of Health prior to burial, creations and the state of | | gave rise to immediate cause (a), stating the DUE TO underlying cause last. | terivocle | retie 8 | cg. Heer Do | rear |
| a a | atte e ha se a th pr | TION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBU | UTING TO DEATH BUT NOT RELA | TED TO THE TERMINAL DE | STASE CONDITION OVEN IN PART 1 | 19. WAS AUTOPSY |
| Ē | al or at ficate h for use Health | CERTIFICATION | 20a. ACCIDENT WAS UNDERLYING 20b. | DESCRIBE HOW INJURY DCCU | DDED (Enter nature of | injury in Part I or Part II of Item 1 | W Mester 190 |
| PHYSICIAN: | certiched ched pt. of | | OR CONTRIBUTING (CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | DESCRIBE INTO MARKE DOGGO | MED. (Eliter haters or | inguity the total to the it of seems a | _ |
| PH | d by the hospita After this certif I be detached for State Dept. of h | MEDICAL | Hour a.m. While | Not While factor | CE OF INJURY (Home, far ry, street, office bldg., etc | m, 20f. (City or town) (C | ounty) (State) |
| DIN | ed b F B b F B b | ≥ | p.m. 19 at word 21. I certify that (I) (this hospital) attend | | Jan / 1 19 | 64 to Felin 9, 19 | (that (I) (we) last |
| N3 LI | etain TOR: Shou | | saw the deceased alive on 2/876 | | death occurred at 2 | M, from the causes and on | the date stated above. |
| | be reserved will | | 22a. SIGNATURE | 4. A/ MD | ATTENDING M | ED. STAFF | DATE SIGNED |
| E | May CAL C | / | 22c. PHYSICIAN'S NAME (Type) | M.D | 22d. ADDRESS | IRECTOR PHYS. | |
| OSP | Page 4 may be retained by t TO FUNERAL DIRECTOR: After director, page 3 should be d should be filed with the State | 23 | | 23c. NAME OF CEMETERY | OD ODSMATODY | 1 23d. (LDCATION (City, town or c | county), (State) |
| 2 | 15 th | 23 | BURIAL, CREMATION, 23b. DATE THEREOF | All Saints | Monie | Venton | Md. |
| | \$ | P | FUNERAL DIRECTOR | ADDRESS | | D BY REGISTRAR 25b. REGISTRA | R'S SIGNATURE |
| | /R A15 (4) | X | mes of Human on | Intla Four | DATTEB | 14 555 1 1924 | 2) |



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 0304 CERTIFICATE OF DEATH and 2 hours after death, USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) PLACE OF DEATH a. COUNTY h. COUNTY sicial and completely filled in by the flease remove carbon papers. Pages 1 and in any event, within 72 hours after mIC WICO MARYLAND TOWN (If outside corporate limits, write RURAL end give nearest town) b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR 13 UR d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE ON A FARM? NO A YES ENINSUL within NAME OF First Middle 4. DATE Month Day Last DECEASED 19 DEATH (Type or print) DATE OF BIRTH AGE (In years | FUNDER 1 YEAR | FUNDER 24 HRS. | last birthday) | Months | Days | Hours | Min. 6. COLOR OR RACE 8. 7 MARRIED AND NEVER MARRIED WIDOWED DIVORCED 12, CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTUPLACE (County & State, or foreign country) TO FURETRIL DIRECTOR After this certificate was least signed by the atterning physician director, page 3 should be detached for use as the burial-transit permit. Then please ishould be filed with the State Dept. of Health prior to burial, cremation, or removal, and in COUNTRY? death certificate be FATHER'S NAME Dry Buc *[]* 15. WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT Address 16. SOCIAL SECURITY NO. 17. (Yes, no, or unkown) [(If yes give war or dates of service)] CAUSE OF DEATH [Enter only one cause per tine for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH law requires that the PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4 O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Page 4 may be retained by the hospital or attending physician. DUE TO Conditions, if any, which (b) gave rise to immediate **OUE TO** cause (a), stating underlying cause last. (C) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO I YES 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) OESCRIBE HOW INJURY OCCURREO. (Enter nature of Injury in Part I or Part II of Item 18.) MEDICAL (County) (State) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bldg., etc.) Hour a.m. While Not While at work OR ATTENDING at work p.m. Ø 19 that (I) (we) last 21, I certify that (I) (this hospital) attended the deceased from M. from the causes and on the date stated above. saw the deceased alive on 💪 and that death occurred at 22b. DATE SIGNED 22a. SIGNATURE ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. au M.O. PHYSICIAN'S 22d. ADDRESS 22c. NAME (Type) (State) BURIAL, CREMATION, 23b. DATE THEREOF 23 c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) REMOVAL (Specify) REDISTRAR'S FUNERAL DIRECTOR D BY REGISTRAR 25b. Litera VR A15 (4) 15M 4-64



FOR STATE DEPE

DEFRITY MEDITY EXAMPLES This cardificate should be executed within 24 hours after death. If any delay scressary, please execute the certificate, mining the word "pending" in gencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department agent, prior to burial, cremation, or removal, and in any event within 72-trong after death. TO FUNERAL DIRECTOR: Page of Health or its designated TO DEPUTY MED

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

| | 03043 | MEDICAL | EXAMINER'S | CERTIFICATE | OF DEATH | 110000 |
|---|--|--------------------------|------------------------------|--|---|--|
| 1. | PLACE OF DEATH | | | 2. USUAL RESIDENCE | | stitution: Residence before admission) |
| | a. COUNTY Wicomico | | 172017-1110 | a. STATE | b. COUI | |
| | b. CITY OR TOWN (if outside cor | porate (Imits. | C. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If o | <u> Hary Land</u> outside corporate limits, wi | Sonarset rite RURAL and give nearest town) |
| | b. CITY OR TOWN (if outside cor write RURAL and give nearest Salisbury | town) | | | Dames Quarte | |
| - | d. NAME OF HOSPITAL OR INSTIT | 1 | spital, give street address) | d. STREET AOORESS | westion duct oo. | e. IS RESIDENCE |
| 1 | Peninsula | General H | ospital | Main | Dood | ON A FARM? |
| } = | NAME OF | First | Middle | Last | Road. | |
| 1 | (Type or print) Robert | Lee | White | | DEATH 2-6 | -66 19 |
| 5, | SEX 6. COLOR OR RA | | NEVER MARRIED | 8. OATE OF BIRTH | 9. AGE (In years | LIFTINDER 1 YEAR HELINDER 24 HRS. |
| | M C | WIOOWED | DIVORCEO | 3-24-51 | last birthday) | Months Days Hours Min. |
| 108 | . USUAL OCCUPATION (Give kind of | work done 10b. Kil | O OF BUSINESS OR | ~ | ite or foreign country) | 12. CITIZEN OF WHAT |
| guj | ing most of working life, even if re Student | etired) INI | Student | Maryl | and | USA |
| 13 | . FATHER'S NAME | | | 14. MOTHER'S MAIDE | | |
| | Cuntter | What to | | Betty | Roberts | |
| | . WAS DECEASED EVER IN U.S. ARMI | DFORCES? 16. S | OCIAL SECURITY NO. 17. | INFORMANT | Addre | \$5 |
| (1) | es, no, or unkown) (If yes give war or d | | - 1 | Vre Bottu | Tonos Domos | Orana trans 163 |
| | 18. GAUSE OF DEATH Enter on | ly one cause per lin | le for (a), (b), and (c).] | H 2 . Denny | DOMES POSITION | Querter-Md |
| | PART I. DEATH WAS CAUSE IMMEDIATE CA | D BY: LI | orrhage | * | | ONSET AND DEATH |
| | GOIV | OUE TO | | | | |
| | Conditions, if any, which } | | shot wound of | chest and a | hdomen | 40 hours |
| | gave rise to immediate | | | | | |
| | cause (a), stating the (| OUE TO | | | | |
| × | PART II. OTHER SIGNIFICANT CON | (c) DITIONS CONTRIBUT | ING TO DEATH BUT NOT REL | ATED TO THE TERMINAL OF | SEASE CONDITION GIVEN IN | PART 1(a) 19. WAS AUTOPSY |
| ATIC | | | | | | YES NO (F) |
| IFIC | 20a. EXTERNAL CAUSE WAS | 20b. 0 | ESCRIBE HOW INJURY OCC | URRED. (Enter nature of | Injury in Part I or Part II | |
| ERT | PRIMARY TOT CONTRIBUTING [CAUSE OF DEATH. | 3 | | | | |
| CAUSE OF DEATH. Shotgun wound of abdomen. Shotgun wound of injury Month, Day, Year 20d, INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, 20f. (City or town) | | | (County) (State) | | | |
| MEDICAL CERTIFICATION | Hour am. | While | Not While at work | ory, street, office bldg., etc | c.) | er Somerset Ld. |
| M | 2 Poline. 2-1-66 21. I certify that I took ch | | | ald an Autoney | | uiry X, and In my opinion |
| | | | | | | |
| | death resulted from: Nat | turai causes, | Accident | icide, Homicid | | I HIGHIICI |
| | ACTUAL E. | 1 6- | 1 | ADDIDITARY MED | | 22. DATE SIGNED |
| | SIGNATURE | - 1 | | M.O. ASSISTANT MED DEPUTY MEDICA | | n // |
| | and the state of t | Royer, M.S. | | Address (Carea | city, town, or county) | ·7 - 66 |
| 23 | | en Ave | a lisbury. Ud. | Y OR CREMATORY | 23d. LOCATION (City, t | own or county) (State) |
| | Burial 2-9 | | Macedonia (| | Dames Quar | |
| 24 | . FUNERAL DIRECTOR | | ADORESS | | C BY REGISTRAR 25b. R | REGISTRAR'S SIGNATURE |
| | 2 7 WEBI | Er Pri | ncess Anne | MD OFEB | 1 1 1966 | 2. Cen Judge |
| | - | | | The same of the sa | 11 | . // // |

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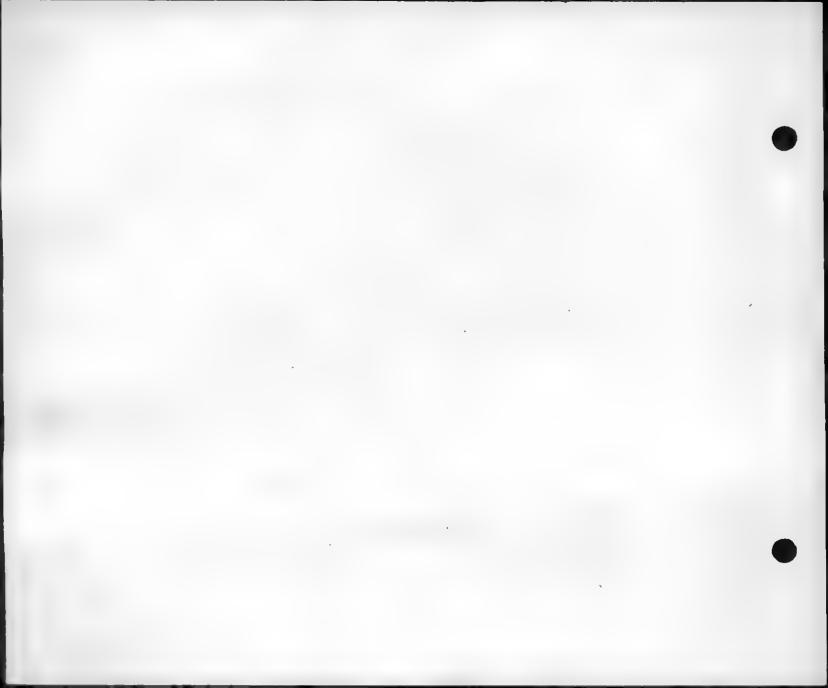


24 hours after death. completely filled in by the funeral modarbon papers. Pages 1 and 2 egent, within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The Iam requires that the Meat certificat me expected mithin Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician app to director, page 3 should be detached for use as the burial-transit permit. Then please refuse should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in day, go

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH | | | | |
|--|---|--|--|--|
| | RESSTER | | | |
| b. CITY OR TOWN (if outside corporate limits, write R write RURAL and give nearest town) C. LENGTH OF STAY IN 1b C. CITY OR TOWN (if outside corporate limits, write R write RURAL and give nearest town) G. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS | 9 3 - 14 | | | |
| Peninsula General Hospital RED | ON A FARM? YES NO | | | |
| NAME OF DECEASED (Type or print) NAME JONES Whitting ton DEATH FEB. | Day Year | | | |
| S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED NOV 1. 1877 9. AGE (In years IFU) Nov 1. 1877 8. DATE OF BIRTH Institution Insti | NDER 1 YEAR FUNDER 24 HRS. Hours Min. | | | |
| Oa. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR UNDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 1 UNDUSTRY 3 OMAL HUME 4 OMAL HUME 3 OMAL HUME 4 OMAL HUME 4 OMAL HUME 4 OMAL HUME 4 OMAL HUME 5 OMAL HUME 4 OMAL HUME 5 OM | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME | 0/3/4 | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Yes, no, or unknown) (If yes give war or dates of service) 215-38-1083 MBS, VILSIE MASSEV. BE | ERLIN MRFD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Engenties For any formal forma | INTERVAL BETWEEN ONSET AND DEATH | | | |
| Conditions, If any, which (b) Applications is Heart Disease | Gean | | | |
| gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART | T1(a) 19. WAS AUTOPSY PERFORMED? | | | |
| 20a. ACCIDENT WAS UNDERLYING TO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Ite OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | m 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bidg., etc.) | (County) (State) | | | |
| 21. I certify that (I) (this hospital) ettended the deceased from | 19 that (I) (we) last | | | |

saw the deceased alive on and that death occurred at 211M, from the causes and on the date stated above. 22b. DATE SIGNED 22a. SIGNATURE ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. M.D. PHYSICIAN'S NAME (TO) 22d. 22c. **ADDRESS** BURIAL, CREMATION, REMOVAL (Specify) (State) 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d_ LOCATION (City, town or county) E614 P 6 ٥ 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

VR A15 (4) 15M 4-64



Item 18 Film G374 3/7/66MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02050 MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT. 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) 1 PLACE OF DEATH o COUNTY Page Wicomico 0 Maryland St. Mary's MARYLAND delay Department b CITY OR TOWN (fouts de corporate limits. CLENGTH OF STAY N 16 c City OR TOWN (If outside corporate limits, write RURAL and give nearest town) pup write RUPAL and give negrest town) after California d NAME OF MOSPITAL OR INSTITUTION (If not in hospital give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? farm hours Item 18 Give Pages Offige polong with far State YES NO X 3 NAME OF Middle Month First 4 DATE DECEASED Christopher OF 2-17-66 the Wilhelmy Bruce 19 within DEATH S SEX 8 DATE OF BIRTH 9 AGE (In years F UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 10st birthday) Months Dovs Hours Oct. 23, 1935 WIDOWED DIVORCED event and 11 BIRTHPLACE (State or foreign country) 10o USUA, OCC. PATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) **INDUSTRY** U. S. Navy Gny Aviator Ohio pages In any ward 'pending' in penal in the Chief Medical Examiner's 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME This certificate shauld be executed within Mary Elizabeth KANE File Christopher Bernard WILHELMY 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address ar remayal, (Yes, no, or unknown) ((If yes give wor or dates of service) 1958-1966 460 64 Official Navy Records Yes 1300 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH Sudden PART (DEATH WAS CAUSED BY: Multiple internal and external injuries, IMMEDIATE CAUSE (a) burial, cremation, DUE TO severe Conditions, if ony, which gove (b) te, writing the v farwarded ta tl rise to immediate couse (a). DUE TO 8 stoting the underlying couse lost. used (19 WAS AUTOPSY PERFORMED? YES NO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION the certificate, p 200 EXTENAL CAUSE WAS PRIMARY LD or CONTRIBUTING LD 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18) prigr 3 should should XIMINIR Airplano crash. CAUSE OF DEATH agent, 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form (City or town) (County) 20c TIME OF NJURY Month, Doy, Year (Stote) While at work of work factory, street, office bldg, etc.) may be retained far yaur FUNERAL DIRECTOR: Page 11 A.M. Salisbury Wicomico Md. 2-17-66 Page designated Inspection [X 21. I certify that I taak charge of the remains described above, held an Autopsy [A Inquiry A and in my apinian Accident X Surcide . funeral director death resulted from Natural causes Undetermined manner Hamicide { CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE Earl L. Royer, MAD DEPUTY MED CAL EXAMINER TO 2-17-66 Б **EXAMINER'S** 5 may 70 FUNE Health NAME (Type) Address (Street, city, town, or county) 1:09 Camden Ave. 6alisbury Md 23c NAME OF CEMETERY OR (REMATORY the th 230 BUR AL CREMATION. 23b DATE THEREO! 23d LOCATION (City or Town) (County) REMOVAL (Specify) Arlington National Arlington. Virginia Burini 24 FUNHALLORFO REC'D BY REGISTRAR 25b REGISTRAR'S S GNATURE VR A15ME (5) Leonardtown. Md. Rubinson -6M 1/66



e. IS RESIDENCE ON A FARM? NOX

Year

19

Hours

INTERVAL BETWEEN

ONSET AND DEATH

19. WAS AUTOPSY PERFORMED?

(State)

that (I) (we) last

(State)

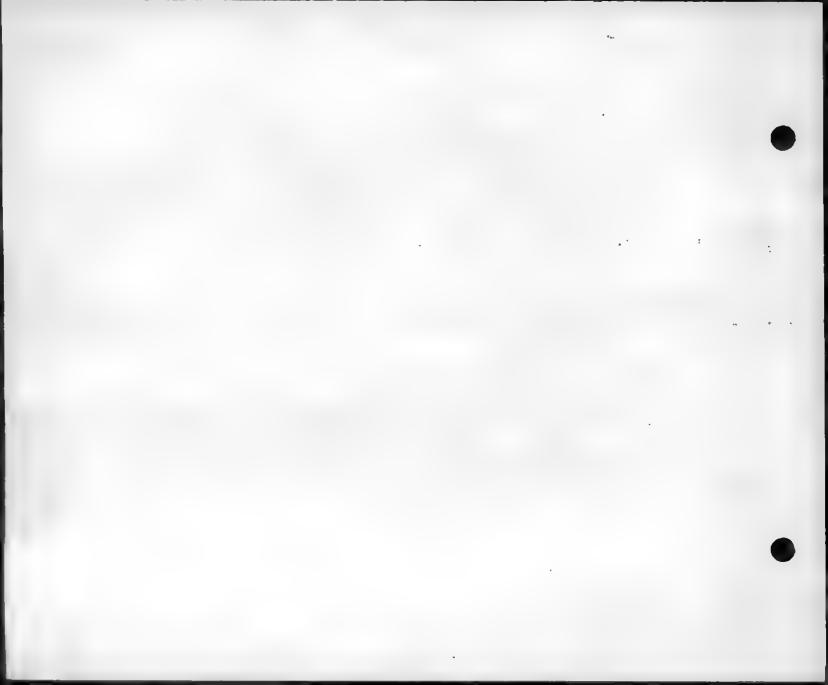
YES

10

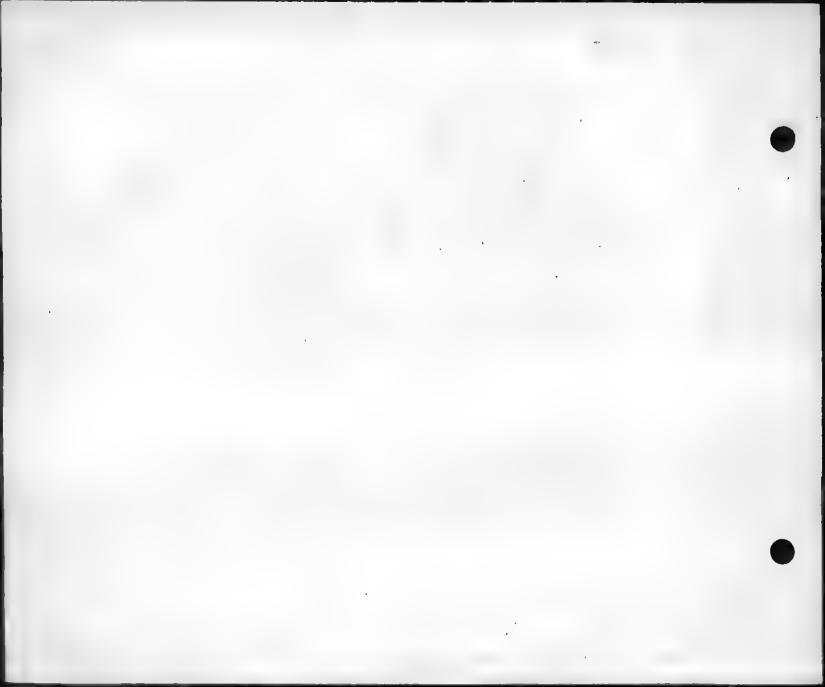
Days

66

VR A15 (4) 15M 4-64



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 1010 CERTIFICATE OF DEATH 03052 funeral and 2 PLACE OF DEATH hours after death, USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY b. COUNTY letely filled in by the furbon papers. Pages 1 a within 72 hours after d 180m100 MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (Ji-putside corporate limits, write RURAL end give nearest town) write RURAL and give nearest tomin) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS ON A FARM? NO [YES ! executed within completely carbon NAME OF Middle DATE Month Lest 4. DECEASED event, (Type or print) DEATH 19 lease remove a 6. COLOR OR RACE AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months | Days | Hours | Min. DATE OF BIRTH 8. 7. MARRIED TV NEVER MARRIED and WIDOWED DIVORCED ogno TOa. USUAL OCCUPATION (Give kind of work done t 10b. KIND OF BUSINESS OR INDUSTRY 11/ BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT physician during most of working life, even if retired) COUNTRY? requires that the death certificate ba hillen 0,11 Cl 272 ᇻ or removal, FATHER'S NAME 14. MOTHER'S MAIDEN NAME attending phermit. Then 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) [(If yes give war or dates of service) INFORMAN 16. SOCIAL SECURITY NO. Address 17. FUNERAL DIRECTOR: After this certificate has been signed by the atten rector, page 3 should be detached for use as the burial-transit permit. nould be filed with the State Dept. of Health prior to burial, cremation, or i 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED the hospital or attending physician. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate DUE TO cause (a). stating underlying cause last. (c) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY for use Health p PERFORMED? NO DZ YES PHYSICIAN: 208. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part 1 or Pert 1) of Item 18.) MEDICAL 120e, PLACE OF INJURY (Home, farm, 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. While Not While β at work at work p.m. be retained director, page 3 should should be filed with the 21. I certify that (i) (this hospital) attended the deceased from and that death occurred at 10 M, from the causes and on the date stated above. saw the deceased alive on 22au S GNATURE 22b. DATE SIGNED DIRECTOR M.D. 4 may PHYSICIAN'S **ADDRESS** (State) 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION town or county) 23a. BURIAL, CREMATION, 2 REMOVAL (Specify) *FUNERAL DIRECTOR* ADDRESS 25a. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE 24 25b. VR A15 (4) 15M 4-64



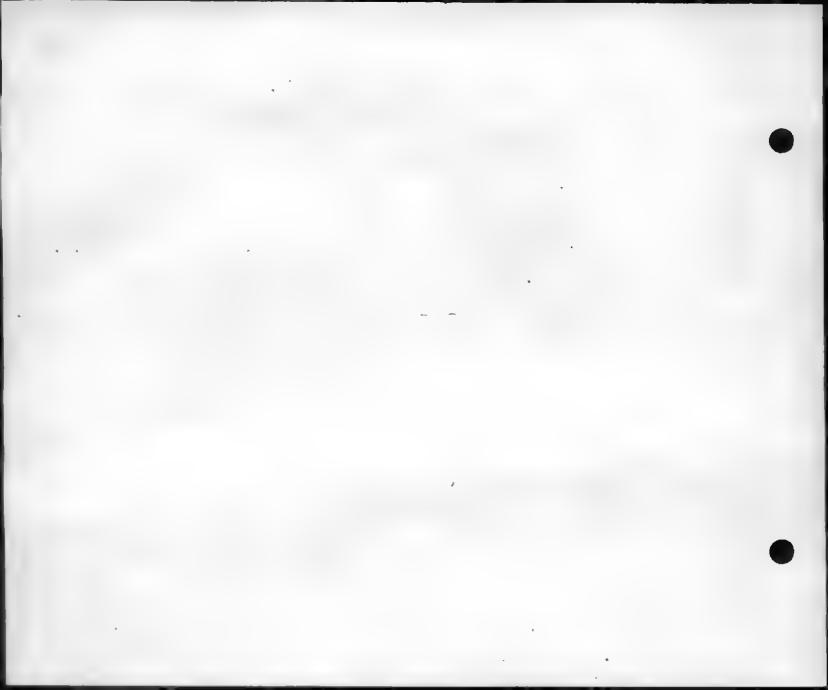
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

| | | E OF DEATH | 00040 | | | |
|--|--|--|---|--|--|--|
| | D. CLAP-OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b (rite RyRAL and give nearest town) | 2. USUAL RESIDENCE (Where deceased lived, If institution: R a. STATE b. COUNTY MD. WICOMIC c. CITY OR TOWN (If outside corporate limits, write RURAL | 0 | | | |
| - 1 | d NAME OF HOSPITAL ON INSTITUTION (If not in hospital, give street address) ENINSULA CENERAL HASPITAL | | e. IS RESIDENCE ON A FARM? YES NO A | | | |
|) | MARKIED A MERCH MARKIED | Last 4. DATE Month DEATH FEDRUTARY 8. DATE OF BIRTH June 4, 1886 4. DATE Month DEATH FEDRUTARY 9. AGE (In years If UNDER last birthday) 79 yrs. | Day Year 19 / 19 / 1 YEAR IF UNDER 24 RRS. Days Hours Min. | | | |
| | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REPIRED PAYMASTER 13. FATHER'S NAME | 11. BIRTHPLACE (County & State, or foreign country) 12. CC CC CC BIVALVE, MD. | TIZEN OF WHAT DUNTRY? J.S.A. | | | |
| | (Yes, no, or unknown) (If yes give war or dates of service) 220-16-9255 A M 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).] | | IMORE, MB. INTERVAL BETWEEN ONSET AND DEATH | | | |
| ス | DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELIED TO CONTRIBUTING TO DEATH BUT NOT RELIED TO CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | t . | 19. WAS AUTOPSY PERFORMED? YES NO | | | |
| 1 | 20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED Hour a.m. P.m. 19 at work 19 at work 21. I certify that (I) (this hospital) attended the deceased from 124, 1960, to 21, 1966, that (I) (we saw the deceased alive on 21, 22, 3)GNATURE Company | | | | | |
| S. S. S. S. S. S. S. S. S. S. S. S. S. S | 23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETER BURIAL Specify 2/23/1966 BIVALVE CEMETER ADDRESS LEVIN R. WILSON PRINCESS ANNE, | PY OR CREMATORY 123d. LOCATION (City, town or complete the complete that the complete the complete that the complete the complete that the complete the complete that the com | 'S SIGNATURE | | | |

VR A15 (4) 15M 4-64

TO MESPILL CONTRIBUTE PROBLEM: The law regules that the death mertificate we executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any other, within 72 hours after deads.



20M 5-63

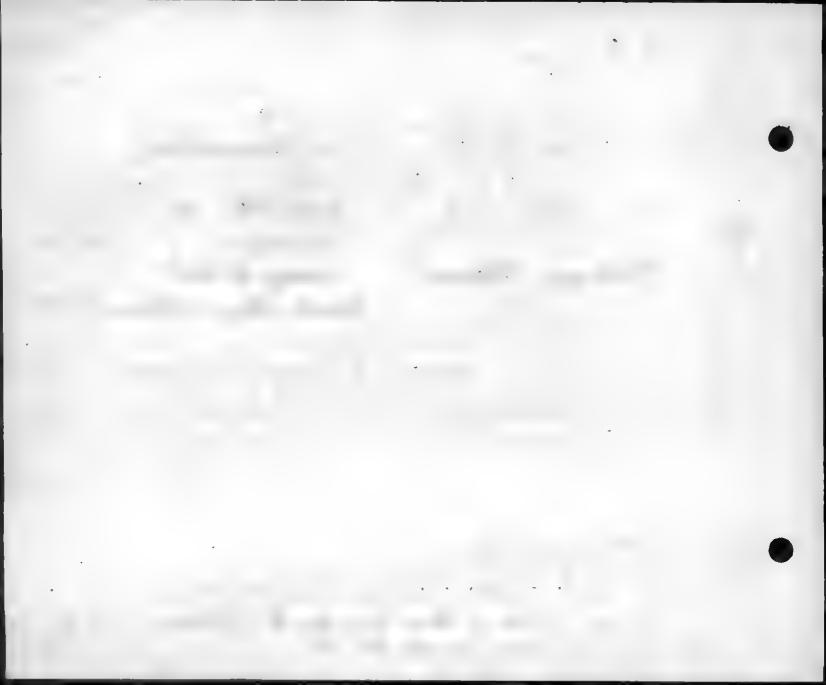
2 IISHBI RESIDENCE Where deceased level if institution, Residence before admitted Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give necest town) IS RESIDENCE ON A FARM? YES TO NO K Buchanan St. Month Day 15 1966 9. AGE (In years LIF UNDER 1 YEAR last birthday 1Db. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? U.S.A. Address Mrs. Myrtle McGuirk, Same INTERVAL BETWEEN ONSET AND DEATH extral humonhage PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISPASE CONDITION GIVEN IN PART 1161 19. WAS AUTOPSY PERFORMED? 2Db. DESCRIBE HOW INJURY OCCURRED. (Entar nature of injury in Part I or Part II of Item 18.) 20f. (City or town) (State) 14 146, and that death occurred atM, from the causes and on the date stated above. 22b. DATE SIGNED PHYS. Salisbury, M ryland 23d. LOCATION (City, town or county) Salisbury, Maryland 25m. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE Hill Funeral Home Salisbury, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH

15M 4-64



54967 and the second of the second of the The state of the s And the second of the second o Control of the second s THE STATE OF THE PARTY OF THE P THE PARTY OF THE P The CA STATE IT ARE I was a supplementary to be a supplementary to the supplementary of the s TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the denth certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL OIRECTOR: After this certificate has been signed by the attending physicial approximation of the funeral director, page 3 should be detached for use as the burial-transit permit. Then please rethous carbon papers. Pages 1 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after directors.

> VR A15 (4) 15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03057
CERTIFICATE OF DEATH

| 06994 | 0-043/ |
|--|--|
| 1. PLACE OP DEATH a. COUNTY | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) |
| «CUCEMICO MARYLAND | a. STATE MILE B. COUNTY Some CSET |
| b. CIFY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside, corporate limits, write RURAL and give nearest town) |
| write RURAL and give nearest town) | 18 - E - 1/1 MM/ 19-3 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | d. STREET ADDRESS e. IS RESIDENCE |
| di dinicali incontinua di incontanti di inco | ON A FARM? |
| LENINSULA CENERAL MISSITAL | 1/4,5,414 3/1 YES NO 1/2 |
| 3. NAME OF PIRST Middle | Last 4. DATE Month Day Year |
| (Type or print) EIFSIH | JOUNG DEATH FEBRUARU - 1966 |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | 8. DATE OF BIRTH 9. AGE (In years IFUNDER YEAR IFUNDER 24 HRS. last birthday) Months Days Hours Min. |
| FRAME NEGLO WIDOWED DIVORCED | Huy: 16, 1977 38 vrs. Monues bays Hours Min. |
| 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT |
| during most of working life, even if retired) INDUSTRY | Christer Pa COUNTRY? |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
| P11-1 m1/ | 1 illian South |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. | INFORMANT Address |
| (Yes, no, or unknown) ((fyespivewar or dates of service) | INFORMANI AUGUST TO I I WE I |
| Me | DOSEPH YOUNG CRISTIELS 1110. |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | 10 0000 |
| 1621 | |
| Conditions, If any, which \ (b) CARCINOMA | - HEPATIE FLEXBRE-COLON. |
| gave rise to immediate | |
| Cause (a), stating the | |
| (6) | ATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 119. WAS AUTOPSY |
| EA THE THE THE THE THE THE THE THE THE THE | PERFORMED? |
| PARTII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELL 20a. ACCIDENT WAS UNDERLYING [] 20b. DESCRIBE HOW INJURY OCC OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | YES NO URRED. (Enter nature of injury in Part 1 or Part II of Item 18.) |
| 208. ACCOUNTRIBUTING CLAUSE OF DEATH OR CONTRIBUTING CLAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | DRKED. (Enter nature of injuly in Part to Part it of Itali 10.) |
| (IF EITHER, NOTIFY MEDICAL EXAMINEK) | |
| fact | GE OF INJURY (Home, farm, 20f. (City or town) (County) (State) |
| Hour a.m. While Not While p.m. 19 at work at work | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| 21. I certify that (I) (this hospital) attended the deceased from | , 19 to -2 5 250, 1966, that (I) (we) last |
| | it death occurred at IIAM, from the causes and on the date stated above. |
| 22a. SIGNATURE, 1 | 22b. DATE SIGNED |
| 1 To tray kear mi M. | D. ATTENDING MED. DIRECTOR D STAFF D 36 21-66 |
| 22c. PHYSICIAN'S | 22d, ADDRESS |
| NAME (Type) | |
| 238. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETER | Y OR CREMATORY 23d. LOCATION (City, town or county) (State) |
| REMOVAL (Spegify) | Part Fred Mind |
| 24. EUNERAL DIRECTOR ADDRESS. | 25a, REC'D BY REGISTRAR 25b, REGISTRAR'S SIGNATURE |
| 24. FUNERAL DIRECTOR ADDRESS. | AA / STATE DE REGISTRAN 230. REGISTRAN 3 SIGNATURE |
| Hulkery Eller Cristilla 1. | Mdi DATE N 3 1956 Januarles Judge |
| a/ | |

